

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 20179	
											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<b>HENRY Phillip BERENDS</b>						<b>August 3, 1980</b>			2:30 A.M.				
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
<b>Male</b>			<b>White</b>		<b>2 - 11 1911</b>			<b>69</b>			IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.		
<b>Md.</b>			<b>U.S.A.</b>					<b>CARROLL</b>			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
<b>Westminster</b>			<b>80 Ridge Road</b>					<b>\\$1600</b>			<b>CITY</b>		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
<b>Md.</b>			<b>Carroll</b>		<b>Westminster</b>						<b>80 Ridge Road</b>		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME								
<b>Henry S BERENDS</b>					<b>Amelia</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
<b>NO</b>			<b>213-01-1274</b>		<b>Thelema BERENDS</b>			<b>about 1 wk.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b>													
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary carcinoma</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Carcinomatosis</b>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>8/2</b> , 19 <b>80</b> , to <b>8/3</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>8/2</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <b>8/3/80</b>	
22b. SIGNATURE <b>Dr. W. Mercer</b>			22c. DEGREE <b>MD</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <b>8-6-80</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Westminster</b>			23d. LOCATION CITY OR TOWN <b>Westminster Carroll Md</b>			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <b>Robert Cole Butcher, Westminster, Md.</b>			25. DATE REC'D. BY REGISTRAR <b>AUG 6 1980</b>										
BP _____													
DHMH - 16 25M (VR A 15 (4) 9/74)													

4 4 0 5 0 6

14

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 0 2 0 7 8 0					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Helen K Biden						Aug 7-1980						525 P M		
3 SEX			4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			REG. NO.				
Female			Caucasian	MONTH	DAY	YEAR	IF UNDER 1 YEAR MONTHS DAYS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
99 United States			10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
90 Manchester			90 Manchester			Long View Nursing Home			Housewife			Carroll County MD.		
13a. STATE Md.			13b. COUNTY Carroll			13c. CITY OR TOWN Finksburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2150 Bethel Rd.		
14. FATHER'S NAME FIRST Gustave			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Weber			Louise			Shapenhorst			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 048-03-8078			17. INFORMANT Mrs Evelyn Biden			ADDRESS 2150 Bethel Rd., Finksburg, Md.			APPROVED AND SIGNED BETWEEN MEDIUM AND DEATH 2 weeks		
18. CAUSE OF DEATH PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292			DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis 5 yrs			DUE TO, OR AS A CONSEQUENCE OF (c)								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Arterosclerotic cardiovascular Disease 2) Perimitis ulcer														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from <u>Aug 14</u> , 1980, to <u>Aug 7</u> , 1980, that (2) we last saw the deceased alive on <u>Aug 6, 1980</u> , 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (3) we (did) did not view the body after death.														
22b. SIGNATURE W.H. Ward MD						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/1/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. Ward MD			22e. ADDRESS 3223 May St Marshall, Md. 21102											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 11, 80			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial			23d. LOCATION CITY OR TOWN Finksburg, Md.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Eline Funeral Home			ADDRESS Reisterstown, Md. 21136			25a. DATE REC'D. BY REGISTRAR Aug. 15, 1980			25b. REGISTRAR'S SIGNATURE Mary McElroy					

1970 C. LIMA DEPT. OF STATE WASH. D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8020781		
1 - STATE REGISTRAR			2a. DATE OF DEATH				2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		MONTH	DAY	YEAR			
Catherine Irene Bombardt							March	22	1980	8 13 80 1235 M		
3 SEX			4 RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			White		Month March Day 22 Year 1980		72			MONTHS YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 24 HRS		
Hampstead			U.S.A.				Carroll			MONTHS DAYS HOURS MIN.		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll County General Hospital				Registered nurse			MD.		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Park Ave		
14 FATHER'S NAME			FIRST	MIDDLE	LAST		15 MOTHER'S MAIDEN NAME			LAST		
			Barton	W.	Taylor		Margaret			Hatton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17 INFORMANT			ADDRESS		
No			215-32-5900				Kenneth E. Taylor			920 Leister's Church Rd. Westminster Md. 21157		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART 1. DEATH WAS CAUSED BY				IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410-											1 HOUR	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			(b) ACUTE MYOCARDIAL INFARCTION									
			(c) ATHEROSCLEROTIC CORONARY HEART DISEASE 7 years									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
					19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE							DEGREE					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)							ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED		
Vincent J. Fiocco										8/13/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial			8/16/80		Oak Lawn Cemetery		Dundalk				Md.	
24. FUNERAL DIRECTOR NAME			Thomas D. Fletcher & Son F.H. 54 East Main Street Westminster, Maryland 21157				25a. DATE REC'D. BY REGISTRAR			25b. REGISTRATION NUMBER		
Dale Fletcher							AUG 18 1980					



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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8020182			
1 - FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>John</i>	MIDDLE <i>H.</i>	LAST <i>Bosley</i>	2a. DATE OF DEATH MONTH <i>09</i>		DAY <i>25</i>	YEAR <i>17</i>	2b. HOUR <i>0005 M</i>				
3. SEX Male		4 RACE White		5 DATE OF BIRTH MONTH <i>09</i>		DAY <i>25</i>	YEAR <i>17</i>	6 AGE (IN YEARS LAST BIRTHDAY) 62		IF UNDER 1 YEAR MONTHS <i>YRS.</i>	IF UNDER 24 HRS HOURS <i>MIN.</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll County</i>				MD.			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County Gen. Hosp.</i>		12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired blacksmith</i>				12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <i>Md.</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Glyndon</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>10 Fiske Ave.</i>					
14. FATHER'S NAME FIRST <i>Elmer</i>		MIDDLE <i>E.</i>	LAST <i>Bosley</i>	15. MOTHER'S MAIDEN NAME FIRST <i>May</i>		MIDDLE	LAST <i>Kennedy</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO <i>W.W.II 218-12-6707</i>		17. INFORMANT <i>Thomas E. Bosley</i>		ADDRESS <i>Glyndon, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4029</i>		CVA						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~5 days</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) <i>HASCVD</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>~10 years</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____									
22a. I certify that (I) (this hospital) attended the deceased from <i>7-31</i> , 19 <i>80</i> , to <i>8/5</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>8/5</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Charles J. Brown Jr. MD</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>8/5/80</i>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Aug. 7, 1980</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Mt. Zion Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Upperco</i>		COUNTY <i>Balto.</i>	STATE <i>Md.</i>				
24. FUNERAL DIRECTOR <i>Eline Funeral Home</i>		ADDRESS <i>Reisterstown, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 7 1980</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McElroy</i>							



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 0 7 8 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
<b>BLANCHE INA GRAMS COCK</b>				<b>AUG 14 1980</b>	<b>6 40 M</b>
3. SEX		4 RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	
<b>FEMALE</b>		<b>WHITE</b>	<b>15-2-1912</b>	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
<b>MARYLAND</b>		<b>UNITED STATES</b>		<b>CARROLL</b>	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
<b>Finksburg</b>		<b>1718 Yorkland Rd</b>			<b>CATERERIA</b>
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
<b>Md.</b>		<b>CARLISLE</b>	<b>WESTSPRING</b>		<b>172 E. MAINE ST</b>
14. FATHER'S NAME		FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME		
<b>CHARLES</b>		<b>W COCK</b>	<b>Ella Weber Grams</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	17. INFORMANT	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<b>NO</b>		<b>281-04-9086</b>	<b>Laura Lee Wilson</b>	<b>FINKSBURG MD</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CENTRAL NERVOUS SYSTEM METASTASIS 3 MONTHS</b>					
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ADENOCARCINOMA LUNG - 1 YEAR</b>					
1629 (c) <b>ADENOCARCINOMA LUNG - 1 YEAR</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 14 80</b> , 19 <b>80</b> , to <b>AUG 14 1980</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>AUG 14 80</b> , 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. THE SIGNATURE <b>Daniel I Welliver M.D.</b>					
22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. DATE SIGNED <b>8-14-80</b>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <b>218 WASHINGTON RD</b>			
<b>DANIEL I WELLIVER</b>		<b>WESTMINSTER MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-18-80</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Rose Hill</b>	23d. LOCATION CITY OR TOWN <b>HAGERSTOWN</b>	STATE <b>Washington 21774</b>
24. FUNERAL DIRECTOR NAME <b>Sister Ed Smith, Westminster, Md.</b>		ADDRESS	25a. DATE REC'D. BY REGISTRAR <b>NOV 25 1980</b>		25b. REGISTRAR'S SIGNATURE <b>Ed Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 4), it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 0 / 8 4					
										REG. NO.					
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			Geraldine C. Cromwell						8 10 80				0330 M		
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			MONTH DAY YEAR May 23, 1911			69		MONTHS DAYS		HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Savannah, Georgia			USA						Carroll						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCLUDE ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Westminster			Carroll Co. Gen. Hosp.			Housewife									
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md.			Balto.			Reisterstown			29 Chestnut Hill Lane						
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME			ADDRESS						
Ernest			A. Croce			Myrtle			Mr. Paul R. Roland Finksburg, Md.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			214-18-1716			Mr. Paul R. Roland							HOURS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>OCCULTION OF DISTAL AORTA</u>															
4441 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROSIS, GENERALIZED, ADVANCED</u> 4 YEARS					
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>MESENTERIC VASCULAR OCCLUSION = HEMORRHAGIC BOWEL</u>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 7/27, 1980, to 8/10, 1980, that (I) (we) lost the deceased alive on 8/10, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										22c. DATE SIGNED 8/10/80					
22b. SIGNATURE <u>Geraldine Cromwell Jr.</u>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug. 13, 80			23c. NAME OF CEMETERY OR CREMATORIAL Security Process			23d. LOCATION CITY COUNTY STATE Baltimore, Md.						
24. FUNERAL DIRECTOR NAME Eline Funeral Home			ADDRESS Reisterstown, Md. 21136			25a. DATE REC'D. BY REGISTRAR AUG 15 1980			25b. REGISTRAR'S SIGNATURE <u>John J. Murphy</u>						

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(VRA 15, 4) 1/79

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P 8 V 0 1 U 8

"favour" "mathematical"

"P" "over" "as" "not" "of" "the"

"flame" "x" "A" "in" "my" "dear"

"stereo" "face" "not" "for" "not" "but"

"and" "the" "dumb" "Q" "mis" "not" "it"

"subject" "after" "second" "A" "so"

"complaint" "make" "B" "not" "any" "not"

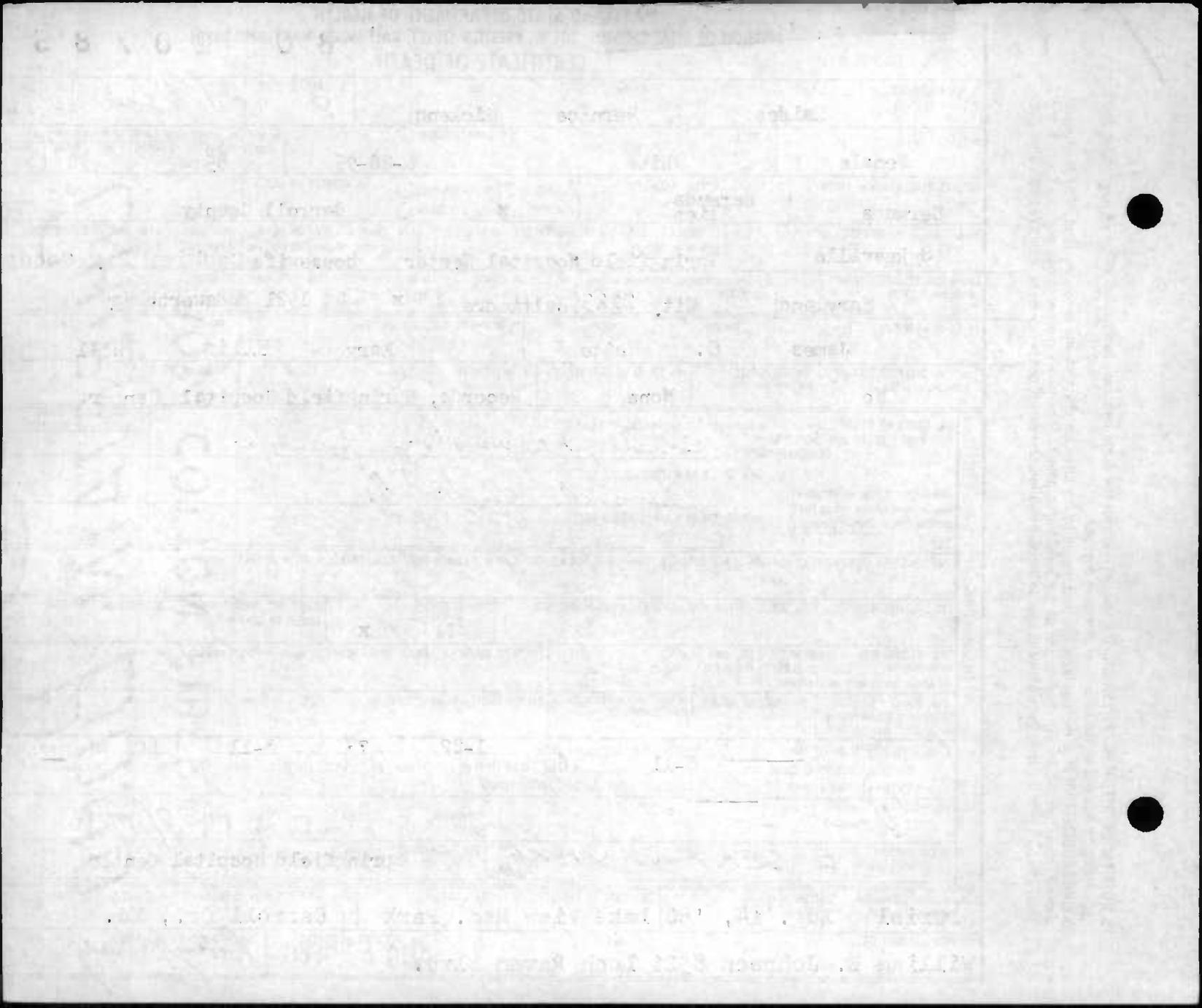
"not" "not" "not" "not" "not" "not"

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

BALTIMORE MARYLAND 21201 0 / 85

1. DECEASED-NAME (Type or print)		First  Haidee	Middle  Bernice	Last  Dickens	2a. DATE OF DEATH  8 Month 11 Day 80 Year	2b. HOUR 6-10 AM
3. SEX  Female		4. RACE  White		5. DATE OF BIRTH  6-28-95	6. AGE (In years last birthday)  85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country)  Bermuda		7b. CITIZEN OF WHAT COUNTRY?  Bermuda Alien		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH  Carroll County	
10. CITY OR TOWN OF DEATH  Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)  Springfield Hospital Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)  housewife	12b. KIND OF BUSINESS OR INDUSTRY  Cashier Dry Goods	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE  Maryland		13c. CITY OR TOWN  City 21239 Baltimore		13d. INSIDE CITY LIMITS?  YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER  1921 Wadsworth Way	
14. FATHER'S NAME First  James		Middle  C.	Last  White	15. MOTHER'S MAIDEN NAME First  Mary	Middle  Ellis	Last  Hill
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  No		16b. SOCIAL SECURITY NO.  None		17. INFORMANT  Records, Springfield Hospital Center	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>cardio-respiratory failure</u>  DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause  <u>7991</u>  (b) <u>terminal debility</u>  DUE TO, OR AS A CONSEQUENCE OF  (c)						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?  YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County
State						
22a. I certify that (I) (this hospital) attended the deceased from 1-22, 19 73, to 8-11, 19 80, that (I) (we) last saw the deceased alive on 8-11, 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE  <u>Amelia</u>						
22c. DATE SIGNFD  8/11/80						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS  E. SENAYAKE		Springfield Hospital Center		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 14, '80	23c. NAME OF CEMETERY OR CREMATORIAL Lake View Mem. Park	23d. LOCATION (City or Town) Carroll Co., Md.	(County)	(State)
24. FUNERAL DIRECTOR William E. Johnson 8521 Loch Raven Blvd		ADDRESS		25a. REC'D. BY REGISTRAR AUG 12 1980	25b. REGISTRAR'S SIGNATURE  Robby McCreedy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8020786			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Edith</i>	MIDDLE <i>J.</i>	LAST <i>Dixon</i>	2a. DATE OF DEATH			MONTH <i>8</i>	DAY <i>1</i>	YEAR <i>80</i>	2b. HOUR <i>5:30 P.M.</i>			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS <i>90</i> YRS		IF UNDER 24 HRS MONTHS <i>0</i> DAYS <i>0</i> HOURS <i>0</i> MIN. <i>0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			MONTH <i>2</i> DAY <i>25</i> YEAR <i>1890</i>			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i>			
10. CITY OR TOWN OF DEATH <i>Hampstead</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4014 Gill Avenue</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Hwf</i>			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE <i>MD</i>			13b. COUNTY <i>CARROLL</i>			13c. CITY OR TOWN <i>HAMPSTEAD</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>4014 Gill Avenue</i>			
14. FATHER'S NAME FIRST <i>Joseph</i>			MIDDLE <i>C.</i>	LAST <i>Parks</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Alma</i>			MIDDLE	LAST <i>Wallace</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>811-18-2478</i>			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost												<i>Cerebrovascular accident</i>			
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (we) attended the deceased from <i>August 1, 1980</i> to <i>August 4, 1980</i> , that (I) (we) last saw the deceased alive on <i>July 19, 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I did not) view the body after death.												22c. DATE SIGNED <i>8/1/80</i>			
22b. SIGNATURE <i>A. J. Martin, M.D.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>			MEDICAL DIRECTOR <input type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>D. V. Martino, M.D.</i>			22e. ADDRESS <i>4111 Lower Beckleysville Road Hampstead, MD 21074</i>												
23a. BURIAL, CREMATION, REMOVAL <input checked="" type="checkbox"/>			23b. DATE <i>8-4-80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Evergreen Mem. Gardens</i>			23d. LOCATION CITY OR TOWN <i>Finksburg</i>			COUNTY <i>Carroll</i>		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Eline Funeral Home, Hampstead, Md.</i>			ADDRESS <i>21-74</i>			25a. DATE REC'D. BY REGISTRAR <i>AUG 13 1980</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>						
DHMH - 16 25M (VR A 15 (4) 9/74)															

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 0 7 8 1	
1 - FOR STATE REGISTRAR			REG. NO.										
I. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
		<b>Virginia Mildred Flickinger</b>			8 21 80						11:30 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			
Female		White		MONTH 4	DAY 30	YEAR 24	56			MONTHS YRS	DAYS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Union Bridge		4865 Bark Hill Rd.										factory worker shoe	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Carroll		Union Bridge						4865 Bark Hill Rd.			
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST			
Carroll		C.		Pittinger	Addie					Wantz			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			4865 Bark Hill Rd.			ADDRESS			
No		none		213-18-9294			Preston Flickinger			Union Bridge, Md.			
18. CAUSE OF DEATH Enter only one cause per line for 1a, 1b, and 1c. PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first { DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC BLADDER CANCER 6 MO.</u> { DUE TO, OR AS A CONSEQUENCE OF (c) _____												1 MIN.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I this hospital) attended the deceased from <u>8</u> 19 <u>77</u> to <u>8</u> 19 <u>80</u> , than (we) last saw the deceased alive on <u>8/21</u> 19 <u>80</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) did/did not view the body after death.												22c. DATE SIGNED <u>8/22/80</u>	
22b. SIGNATURE <u>John M. Lehigh</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John M. Lehigh</u>			22e. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION near TOWN		COUNTY	STATE			
Burial		8/24/80		Pipe Creek Cemetery			New Windsor		Carroll	Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
<u>J. D. Hartzer</u>		<u>Union Bridge, Md.</u>			AUG 25 1980			<u>Patsy McCloud</u>					

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the 28th  
the 29th  
the 30th  
the 31st

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it  
should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH : 8 0 2 0 / 8 8										REG. NO.
1 - FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
	ALVA	CATHERINE	FOGLE		8-20-80				4 P M	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
FEMALE	CAUCASIAN	7 - 31 - 00			80			IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND	USA				CARROLL COUNTY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
TANEYTOWN	2730 ROOP RD. TANEYTOWN, MD.			HOMEMAKER			Own Home			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MARYLAND	CARROLL	TANEYTOWN				2730 ROOP RD.				
14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST			
MILTON	-	EYLER	ANNIE				BAUGHER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO.	16b. SOCIAL SECURITY NO. 219-12-1306			17. INFORMANT OSCAR FOGLE			ADDRESS ROOP RD, TANEYTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GASTROINTESTINAL BLEEDING</u> <u>2390</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>INTESTINAL TUMOR (TYPE UNKNOWN)</u> (c) <u>ONE YR.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (we) attended the deceased from <u>8-15</u> , 19 <u>77</u> , to <u>8-20</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>8-19-</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death										22c. DATE SIGNED <u>8-20-80</u>
22b. SIGNATURE <u>WILLIAM R. LINTHICUM, M.D.</u> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED <u>8-20-80</u>
22e. ADDRESS <u>TANEYTOWN, MARYLAND 21787</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 23, 1980	23c. NAME OF CEMETERY OR CREMATORIAL Rocky Hill Cemetery	23d. LOCATION CITY OR TOWN Woodboro, Frederick Co., MD			23e. COUNTY Frederick Co., MD				
24. FUNERAL DIRECTOR NAME Skiles Funeral Home	136 E. Baltimore Street TANEYTOWN, MD 21787			25a. DATE REC'D. BY REGISTRAR <u>AUG 25 1980</u>	25b. REGISTRAR'S SIGNATURE <u>Jerry McElroy</u>					

6  
U.S. GOVERNMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

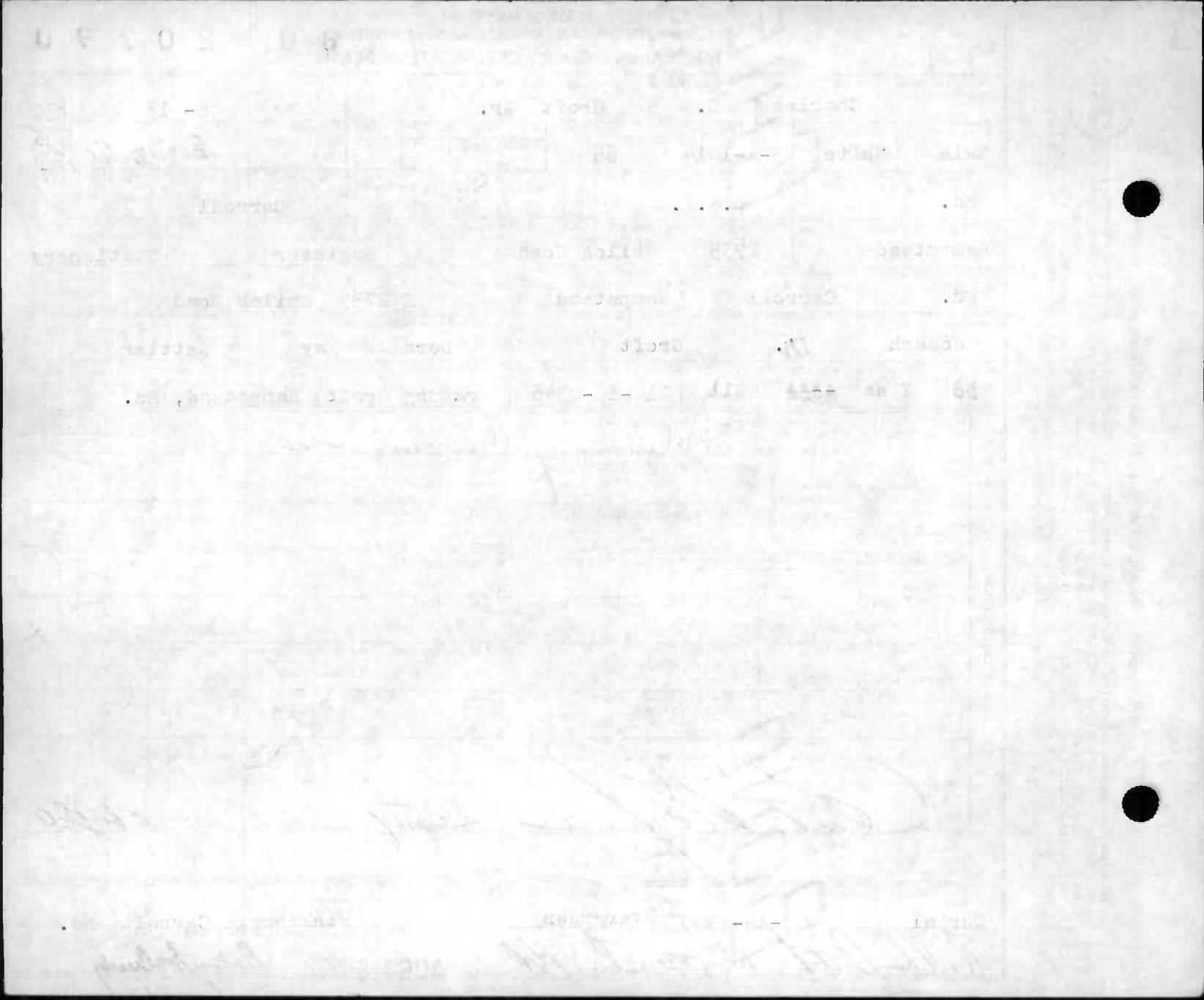
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	0	2	0	7	8	9
										REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Cleedie Viola Frick						August 3 1980			4:30P M				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			Sept. 24 1896			83			MONTHS		DAYS HOURS MIN		
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Smallwood			U.S.A.						Carroll MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Westminster			529 Poole Rd.			Housewife			21157							
13a. STATE Maryland			13b. COUNTY Carroll			13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 529 Poole Rd. Westminster, Md.				
14. FATHER'S NAME FIRST Ephram			MIDDLE			LAST Williams			15. MOTHER'S MAIDEN NAME Susie			LAST Frizzell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			220-16-1753			Donald E. Frick			521 Hook Rd. West. Md. 21157							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardiac Infarction - Acute</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ASVD</i>																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <i>June 10 1980</i> to <i>August 3 1980</i> , that <input type="checkbox"/> (we) last saw the deceased alive on <i>July 23 1980</i> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.																
22b. MEDICAL CERTIFICATION DEGREE <i>Dr. H. S. J.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <i>8-4-80</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dean H. Griffin MD										22e. ADDRESS Ridge Rd. Westminster, Md. 21157						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8/6/80			23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery			23d. LOCATION CITY OR TOWN Westminster Carroll Md.			COUNTY STATE				
24. FUNERAL DIRECTOR NAME <i>Dal Fletcher</i>			Thomas D. Fletcher & Son F.H. 204 East Main Street Westminster, Md. 21157			25a. DATE REC'D. BY REGISTRAR AUG 7 1980			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

0000 1246

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY EXECUTE THE CERTIFICATE, WRITING THE WORD 'PENDING' IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR PRACTICE. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8020790				
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI. DEATH MATED		MONTH	DAY	YEAR	2b. HOUR
Charles W. Groft Sr.											<input type="checkbox"/> 8-13 1980		08	13	80	A 830 M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.					2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
Male	White	3-1-1914	66	MONTHS	DAYS	HOURS	MIN		8-13 1980	08	13	80	M 23			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll						
10. CITY OR TOWN OF DEATH Hampstead		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2735 Shiloh Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer			12b. KIND OF BUSINESS OR INDUSTRY Stationery								
13a. STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Hampstead	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2735 Shiloh Road											
14. FATHER'S NAME Joseph		MIDDLE T.M.	LAST Groft	15. MOTHER'S MAIDEN NAME Dora May		16. SOCIAL SECURITY NO. 214-16-0346			17. INFORMANT Mrs Ruby Groft		ADDRESS Hampstead, Md.					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> (If yes, give rank or grade) WWII		18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Congestion</i> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) _____ DUE TO, OR AS A CONSEQUENCE OF  (c) _____			18c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
18d. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input checked="" type="checkbox"/> Accidents <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/>									and in my opinion					
ACTUAL SIGNATURE <i>Patricia M. Groft</i>		TITLE SPECIFY M.D.			MEDICAL EXAMINER						DATE SIGNED <i>14 Aug 80</i>					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE				
Burial		8-16-1980			Evergreen			Finksburg		Carroll		Md.				
24. FUNERAL DIRECTOR NAME		DRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
C. M. Groft Westminster P.C.								AUG 19 1980								
BP _____																
DHMH - 17 (VR A15 M51) 15M 7/76																



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR SELVES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W/PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8020791											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			IN HOME					
DONALD LEROY Hare												<input type="checkbox"/> 8 8 1980			8 8 1980			M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.											
M		Wht.		Aug 17 1925			54 yrs.			MONTHS		DAYS		HOURS		MIN.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Carroll									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			4314 Millers Station Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Plumber			12b. KIND OF BUSINESS OR INDUSTRY			Plumbing						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			4314 Millers Station Road										
Md		Carroll		Millers			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																
14. FATHER'S NAME		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			MIDDLE			LAST									
Jesus		C			Hare			Hilda			?			Graf									
16a. WAS RELEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN). (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Yes WW II		220-18-2478			Hilda H. Hare. Millers, Md 21107																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot Gun Wound to Head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>Sel'd, infected</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																							
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). <u>Know Cancer w/ma of lung, terminal</u>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20. AUTOPSY?														
									<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. LOCATION STREET			21d. CITY OR TOWN			COUNTY			STATE								
21e. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)																				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE <u>Richard A. Jones, M.D.</u>															TITLE SPECIALTY <u>Deputy</u> M.D. MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT)			RICHARD A. JONES			ADDRESS			WESTMINSTER, MD.			DATE SIGNED 8 Aug 80											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE								
Burial			8/11/80			new Lutheran Cem.			Manchester, Md.														
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. RECORDED THIS SAME DAY														
H. J. Eckhardt			Manchester, Md.			AUG 13 1980																	

0006813004

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

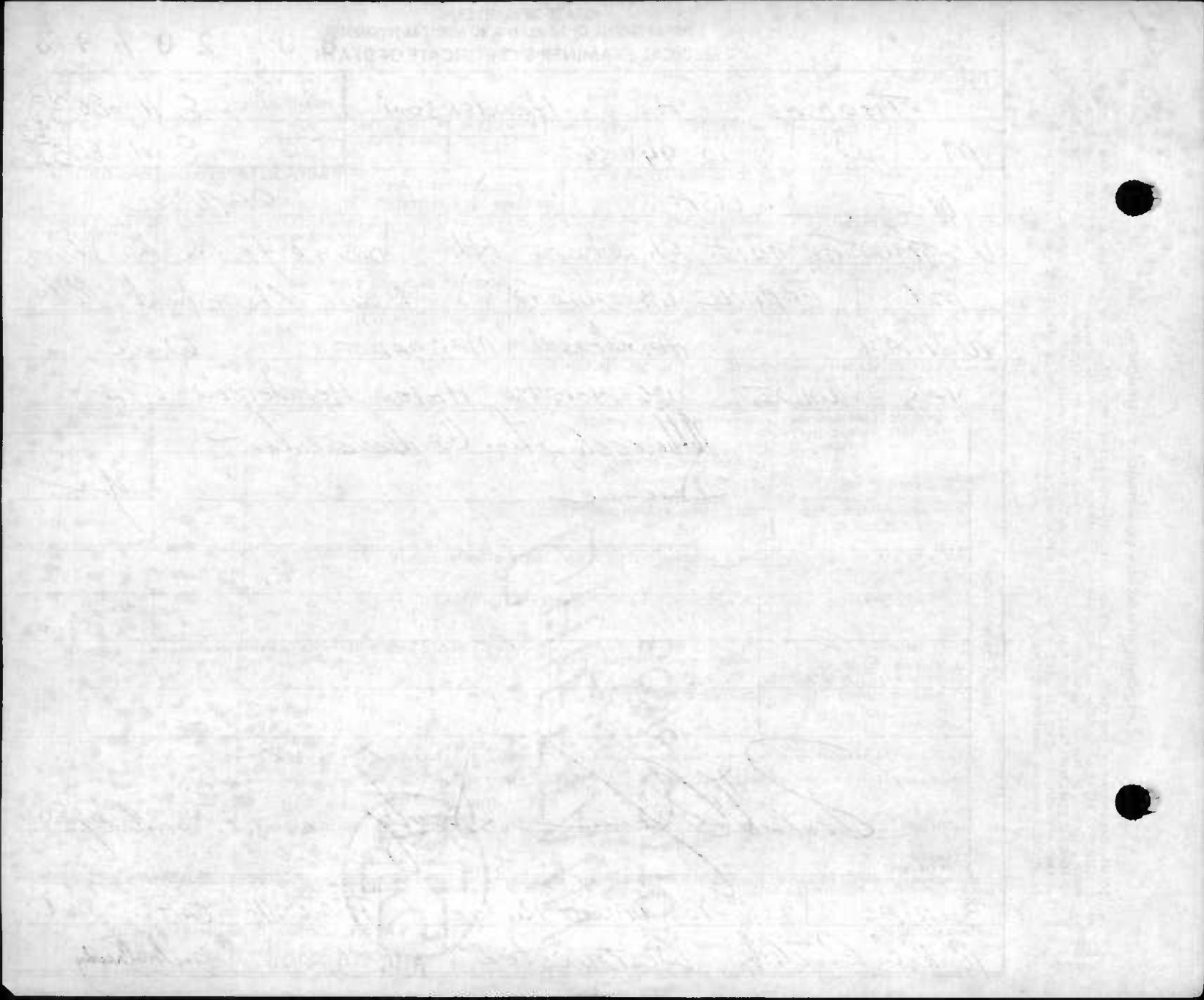
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020192		
1 - STATE REGISTRAR			REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2 DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
	William	Francis	Harrington	8	31	18	8	14	80	0835 M		
3 SEX	4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	White	MONTH	DAY	YEAR	61	YRS.	MONTHS	DAYS	HOURS	MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll							
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK OR TRADE OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Westminster	Carroll County General Hosp.					mechanic					fuel company	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland	Frederick	Union Bridge	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	ES	Bess Clemson Rd.						
14 FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
Howard			Harrington	Lillian					(unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Yes	WW II	220-03-2979			Dorothy G. Harrington Union Bridge, Md			IMMED.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY												
IMMEDIATE CAUSE (a) CARDIAC ARREST												
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CORONARY YEARS												
DUE TO, OR AS A CONSEQUENCE OF (c) HEART DISEASE												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a I certify that (1) (this hospital) attended the deceased from 19 77 to 8/14 19 80, that (1) (we) lost saw the deceased alive on 8/15 19 80, and shot in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE DEGREE												
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22c. DATE SIGNED 8/14/80												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			22f. ADDRESS							
Vincent J. Fiocco		8 Anchor St. Westminster, Md. 21157										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Burial		8/17/80		Mt. View Cemetery			Union Bridge Carroll Md.					
24. FUNERAL DIRECTOR (NAME)		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
G. D. Hartler Elmonbridge, Md.					AUG 18 1980			Helen McCreary				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILE.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8020193		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED			MONTH	DAY	YEAR	EL. HOUR		
Thomas A. Henderson						<input checked="" type="checkbox"/>			8	11	1980	3		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	EL. HOUR		
M	W	6 12 94	86 yrs.	MONTHS DAYS	HOURS MIN	<input checked="" type="checkbox"/>			8	11	1980	3		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
N.J.			USA						CARROLL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY					
WESTMINSTER			4215 Rhinehart Rd.			OWNER Clerk Building								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
MD			CARROLL			WESTMINSTER						4215 Rhinehart Rd.		
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST					
William						Margaret						Wall		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Yes			WWI			126-14-1574A			Helen Henderson s/a			Year		
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.														
(b) <u>Stroke</u> DUE TO, OR AS A CONSEQUENCE OF														
(c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22. I certify that I took charge of the remains described above, held at Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Deputy</u> TITLE SPECIFY <u>M.D.</u> MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT)														
ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION OR TOWN			23e. COUNTY		23f. STATE
Burial			8-16-80			Dove Ridge			Pylesville			Bart.		Md.
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
R. Kyle Ruth Jr.			Westminster			AUG 19 1980			Peter McCreedy					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do so by be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. The please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020794			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Cora Jane Hetrick						Aug 3 1980						1145P M	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
female			white	May 31 1885			95			MONTHS	DAYS	HOURS	MIN
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Carroll's			USA						Carroll				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Linthboro			Home			Housewife			own home				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Md			Carroll			Linthboro						4128 E Main St	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						Bolling Jr	
Charles F			Zigler			Lydia							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			219-03-34384128			MFS Helen Rose							
PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF  (b)  DUE TO, OR AS A CONSEQUENCE OF  (c)			antemortem Heart Disease 5 yrs  generalized arteriosclerosis 5 yrs							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED  WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from April 1980 to Aug 3 1980, to Aug 3 1980, that (I) (we) lost saw the deceased alive on -out 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did/did not view the body after death.													
22b. SIGNATURE						DEGREE			22c. DATE SIGNED				
W H Foard MD									8/3/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
W H Foard MD			3223 Main St March St, Md 21102										
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN				
Burial			Aug 4, 1980			Layman's U.C.C.			Linthboro Carroll Md				
24. FUNERAL DIRECTOR NAME			ADDRESS			25. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Lee Geibler			Glenrock Dr			AUG 11 1980			Lee Geibler				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8020795								
												REG. NO.								
1 - STATE REGISTRAR			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR											
1. DECEASED NAME (TYPE OR PRINT)			ELIZABETH F. HOFMEISTER			August 16, 1980			6 P.M.											
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN										
Female		White		July 17, 1901			79			YRS										
7a BIRTHPLACE (COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Carroll			10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen. Hosp.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b KIND OF BUSINESS OR INDUSTRY MD.		
13a STATE Md.		13b COUNTY Balto.		13c CITY OR TOWN Owings Mills			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 12026 Park Heights Ave.										
14 FATHER'S NAME FIRST MIDDLE LAST			Theodore Kolbe			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			Charlotte Greenburg											
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b SOCIAL SECURITY NO. 212-50-4923			17 INFORMANT Mrs. Mary E. Fitchett			ADDRESS Owings Mills, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EDEMA</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 HRS								
492- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>COP PULMONALE, SEVERE</u> (c) <u>EMPHYSEMA, SEVERE</u>												YRS YRS								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, FARM, ETC. 1805 HPS 316			21f LOCATION STREET 1820 HPS 316			COUNTY STATE											
22a I certify that (if this hospital) attended the deceased from <u>Aug. 80</u> to <u>Aug. 80</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated so far as I was aware, (I) we did not view the body after death.																				
22b SIGNATURE <u>M. SUSAN BOLLINGER</u>			DEGREE MD.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 8/16/80											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>M. SUSAN BOLLINGER</u>			22e ADDRESS WASA 1765 MED. CTR. WESTMINSTER																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE Aug. 13, 80			23c NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery			23d LOCATION PIKEVILLE, MD.											
24 FUNERAL DIRECTOR NAME Eline Funeral Home			ADDRESS Reisterstown, Md. 21136			25a DATE REC'D. BY REGISTRAR AUG 18 1980			25b REGISTRAR'S SIGNATURE <u>Lily McCloud</u>											

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21201

CERTIFICATE OF DEATH

8 3 2 0 / 9 6

1		1. DECEASED NAME (Type or print)		First <b>Louise</b>	Middle <b>Edna</b>	Last <b>Hunt</b>	2a. DATE OF DEATH 08 Month 06 Day 80 Year	2b. HOUR A 11:40		
2		3. SEX		4. RACE <b>Female</b>	White	S. DATE OF BIRTH <b>10-6-12</b>	6. AGE (In years last birthday) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
3		7. BIRTHPLACE (State or foreign country) <b>Maryland</b>		8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. COUNTY OF DEATH <b>Carroll County</b>		Md.		
4		10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield Hospital Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		
5		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>City</b>		13c. CITY OR TOWN <b>Baltimore</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3513 Greenmount Avenue</b>		
6		14. FATHER'S NAME First <b>John</b>		Middle <b>Mahle</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Mary</b>	Middle <b>Louise</b>	Last <b>Keller</b>		
7		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-16-5030</b>		17. INFORMANT <b>Mrs. Bessie Kreis</b> 3523 Abbie Place, Baltimore, MD 21207		Address		
8		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic carcinoma</b> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
9		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Schizophrenia, chronic undifferentiated type</b>								
10		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
11		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
12		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
13		22a. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> , 19 <b>78</b> , to <b>08-06</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>08-06</b> 19 <b>80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
14		22b. SIGNATURE <i>Suha Ozgun, M.D.</i>		DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>08-06-80</b>		
15		22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun, M.D.</b>		22e. ADDRESS <b>Springfield Hospital Center</b> <b>Sykesville, MD 21784</b>						
16		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/8/80</b>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Lorraine Park</b>	23d. LOCATION (City or Town) <b>Woodlawn</b>	(County) <b>Baltimore</b>	(State) <b>MD</b>		
17		24. FUNERAL DIRECTOR Loring Byers Funeral Directors, P.A. 8728 Liberty Rd., Randallstown, MD 21133				25a. REC'D BY REGISTRAR <b>AUG</b>	25b. REGISTRAR'S SIGNATURE <i>Anthony McReady</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020197					
										REG. NO.					
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		8/30/80			130 P.M.					
MARY E. Julian															
3. SEX			4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)									
FEMALE			Caucasian	MONT. DAY YEAR		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.								
Maryland			USA												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
SYKESVILLE			GOLDEN AGE GUEST HOME							None			—		
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
Maryland			Carroll	Sykesville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1442 Buskhorn Rd.		UNKNOWN			UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO			217-88-2818		Golden Age Guest Home, Sykesville, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
5908 Chronic renal failure Nov 1979															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelonephritis															
{ DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. LOCATION STREET		CITY OR TOWN COUNTY STATE			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept 19, 1979, to Now, 19_____, that (I) (we) last saw the deceased alive on 8/27/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED 8/30/80					
22b. SIGNATURE J.H. Caricore M.D.										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS		22e. ADDRESS										
J.H. Caricore M.D.			104 N. Main St. Union Bridge, Md.		104 N. Main St. Union Bridge, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23d. LOCATION CITY OR TOWN			23d. LOCATION CITY OR TOWN				
Burial			9-4-1980	Bethany		Carroll, Md.									
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.			ADDRESS		25. DATE REC'D. BY REGISTRAR SEP 8 1980							25b. REGISTRAR'S SIGNATURE John Murphy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS			7. IF UNDER 24 HRS HOURS MIN			
Ada K. Knighting						5	7	1888	92	YRS.		055A			
3. SEX Female			4. RACE White			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.			
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen'l Hospital			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) HWT			12b. KIND OF BUSINESS OR INDUSTRY						
13. STATE Md.			13. CITY OR TOWN Balto			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14. STREET ADDRESS 34 Hanover Road						
14. FATHER'S NAME Robert			15. MOTHER'S MAIDEN NAME Southard			16. SOCIAL SECURITY NO. 216-46-0129			17. INFORMANT Mrs. Frank Shilling, Hampstead, Md.						
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days Years			
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____	
22a. I certify that (1) (this hospital) attended the deceased from 7-31, 19 8-2, to 8-4, 19 80, that (1) (we) lost saw the deceased alive on 8-3, 19 80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (declined not) view the body after death.															
22b. SIGNATURE Hue Baker			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 8-4-80						
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Hue Baker						22f. ADDRESS 218 Washington Heights Med Ctr Westminster MD 21157									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8-6-80			23c. NAME OF CEMETERY OR CREMATORY Reisterstown Cem.			23d. LOCATION CITY OR TOWN Reisterstown STATE Md.						
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 13 1980			25b. REGISTRATION NO. 7						

of Normal

2nd Industrial Standard Normal

level of normal

standard deviation

666 1200

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

8 0 2 0 7 9 9

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)				First <b>Elmer</b>	Middle <b>(NMN)</b>	Lost <b>LOMAX Sr.</b>	2a. DATE OF DEATH 8 Month 25 Day 80 Year	2b. HOUR 6:20 AM	
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH <b>Sep. 10-19-18</b>		6. AGE (In years lost birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <b>Carroll County, Md.</b>			
10. CITY OR TOWN OF DEATH <b>Sykesville, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield Hosp. Center</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>4017 Boarman Avenue</b>			
14. FATHER'S NAME First <b>Phil</b>		Middle <b>Byrdx</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Viola</b>		Middle		Last <b>Balls</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>unknown 217-07-1286</b>		17. INFORMANT <b>Shirley Lewis</b> Address <b>Hospital Records - Springfield Hosp. Ctr.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ASPIRATION PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause last. (c)									
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b>									
<b>MEDICAL CERTIFICATION</b>		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
<b>22a. I certify that (s)(this hospital) attended the deceased from 8-20, 19 80, to 8-25, 19 80, that (s)(we) last saw the deceased alive on 8-25 19 80, and that in (s)(our) opinion death occurred on the date and hour and from the causes stated above, (s)(we) did (did not) view the body after death.</b>									
22b. SIGNATURE <i>Elmer</i>		DEGREE	ATTENDING PHYS.	<input type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>8-25-80</b>			
22d. PHYSICIAN'S NAME (Type) <b>E. SENANAYAKE, MD</b>		22e. ADDRESS <b>Springfield Hospital Center Sykesville, Maryland 21784</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-30-80</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Balto. Cem.</b>		23d. LOCATION (City or Town) <b>Baltimore</b>		(County) (State) <b>Md.</b>	
24. FUNERAL DIRECTOR <b>W.C. March 1100 E. North Ave.</b>		ADDRESS		25a. REC'D. BY REGISTRAR <b>AUG 29 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Henry McAleney</i>			

RENTAL

(RE)

RENTAL

10

SI-2P-01

RENTAL

RENTAL

100% Return

100% Return

return amount 100%

amount 100%

amount 100%

RENTAL

RENTAL

100% Return - deposit return - 100% amount - 100%

100% -

amount for liquid distribution  
100% amount of revenue

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8020800					
1 - STATE REGISTRAR			REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
ROBERT REESE LOVELL						8-11-80						7:45 P.M.					
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
M			W	MONTH	DAY	YEAR	67 yrs.			MONTHS	OAYS	HOURS	MIN.				
2. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
BALTIMORE			USA						CARROLL COUNTY								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
HAMPSTEAD			1427 N. Main Street									RETIRED			NONE		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
MARYLAND			CARROLL			HAMPSTEAD						1427 N. MAIN STREET					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
JACOB			R	LOVELL		GOLDE			A.	REESE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR GATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
No			216-10-0273			JOAN LOVELL - SAME											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). CARCINOMA LARYNX APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) METASTASIS TO LIVER																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) NONE																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
12/13/79			CARC OF CA LARYNX						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
NO			P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/11/80, 19, to 8/11/80, 19, that (I) (we) last saw the deceased alive on NO 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED								
Meijers												8/11/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			MD.											
S. D. MORJARIA			3125 MAIN STREET, MANCHESTER 21102														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY STATE					
BURIAL			8-13-80			EVERGREEN MEMORIAL GARDENS, FINKSBURG, MD 21048											
24. FUNERAL DIRECTOR NAME			ADDRESS			MD. 21074			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Elaine Funeral Home			JERRY ELINE, HOUKESVILLE RD, HAMPSTEAD			AUG 15 1980											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal with the medical examiner.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8020801 REG. NO. 815-D		
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR		
			Carrie Belle Mann						8-2-80			30 12 P.M.		
3. SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
F			Caucasian			7-1-86			84 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Carroll County USA									Carroll					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY					
Manchester			Long View Nursing Home			Housewife			Home					
13a STATE Md.			13b COUNTY Carroll			13c CITY OR TOWN Finksburg			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS Bethel Rd.		
14. FATHER'S NAME FIRST Joseph			MIDDLE			15. MOTHER'S MAIDEN NAME LAST Leppo			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			ADDRESS 760 Elm Spring		
									16b SOCIAL SECURITY NO 219-03-013661			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Dr. John I. Mann Pittsburgh, Pa 15243		
						17. INFORMANT								
						Dr. John I. Mann								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						ATHEROSCLEROTIC HEART DISEASE								
2500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF INSULIN DEPENDENT DIABETES MELLITUS.								
			(c)			DUE TO, OR AS A CONSEQUENCE OF FRACTURE FEMUR RIGHT SIDE								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
ORGANIC PSYCHOSIS														
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1978, 19 to 8/2/80, 19 80, that (I) (we) last saw the deceased alive on 7/6/80, 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Mayans						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/2/80		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S.D. MORJARIA			22e. ADDRESS 3125 MAIN STREET, MANCHESTER									22f. DATE SIGNED 8/2/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-5-80			23c. NAME OF CEMETERY OR CREMATORIAL BETHEL			23d. LOCATION CITY OR TOWN Westminster Carroll Md			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Robert J. Smith Jr ADDRESS														

6

**HOSPITAL OR ATTENDING PHYSICIAN:** The physician retained by the hospital or attending physician

Death certificate be executed within 24 hours after death Page 4 may be

NO FUNERAL DIRECTOR, ATTEMPTING TO USE THIS VEHICLE FOR ANYTHING OTHER THAN A BURIAL OR Cremation, SHOULD BE DETECTED FOR USE AS THE BURIAL-TRANSIT PERMIT. THEN PLEASE REMOVE CARBON PAPERS. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020802
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST Martha	MIDDLE B.	LAST Moran		2a. DATE OF DEATH August 24, 1980			2b. HOUR 7 A.M.
3. SEX Female			4. RACE White		5. DATE OF BIRTH May 1, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 82			IF UNDER 1 YEAR YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll			IF UNDER 24 HRS MONTHS DAYS HOURS MIN
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET, ADDRESS 134 Dixon Lane		
14. FATHER'S NAME FIRST James			MIDDLE Horton	LAST Bishop	15. MOTHER'S MAIDEN NAME Kizah					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 226 92 0930		17. INFORMANT Thelma F. Woody			ADDRESS Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cardiac arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD, hypertension, mild cardiac failure, } DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis (generalized), arthritis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (the hospital) attended the deceased from 1974 19 to 1980 19, that (I) (we) lost saw the deceased alive on 8-24-80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Howard E. Hall</i>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-24-80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Howard E. Hall		22e. ADDRESS Sykesville, Md. 21784								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-80		23c. NAME OF CEMETERY OR CREMATORIAL Fairwood Cemetery		23d. LOCATION CITY OR TOWN Frederick, Md.		23e. COUNTY Md.		
24. FUNERAL DIRECTOR NAME Kerry W. Haight		ADDRESS Sykesville, Md.		24. DATE RECEIVED BY REGISTRAR THE REGISTRAR'S SIGNATURE AUG 29 1980						

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6 Jan 62

additives

aspirin

chloroform

600 & 200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8020803			
												REG. NO.			
1. FOR - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
MARK			M MOXLEY						8 - 20 - 80			1110 M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			7. IF UNDER 24 HRS					
MALE		CAU.		01 - 07 - 86			94 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL County MD.								
MARYLAND		U.S.A.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
WESTMINSTER		WESTMINSTER Nursing & Convalescent		FARMING			FARM								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
Maryland		Howard		Ellicott City			A			9232 RT #99					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
EZEKIAL R MOXLEY		LOLA EMMA MELLOR													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		217-01-0312			CATHERINE A. BUTLER			9232 RT 99 Ellicott City MD 21043			Years				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)  4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).  DUE TO, OR AS A CONSEQUENCE OF (b).  (c)  DUE TO, OR AS A CONSEQUENCE OF (c).															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____										
22a. I certify that (I) (this hospital) attended the deceased from 5-27 1976 to 8-20 1980 that (we) last saw the deceased alive on 8-16 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did not view the body after death.															
22b. SIGNATURE <i>Alma Moxley MD</i>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8-20-80							
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/23/80			23c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd Cem.			23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____			Ellicott City, Howard, Maryland				
24. FUNERAL DIRECTOR NAME SLACK Funeral Home, Ellicott City, Maryland 21043		ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 26 1980			25b. REGISTRAR'S SIGNATURE <i>John J. Slack</i>							
BP															
DHMH-16 50M 7/77 (VR A 15 (4))															



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR  
STATE  
REGISTRATION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 0 2 0 8 0 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Robert Harrison Proctor						8	16	80		1510 P.M.		
1. SEX	4 RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
Male	Negro	5-16-1912				68	YRS.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA						Carroll MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY					
West Minister	Carroll County Hospital					NA						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RFD					
13a. STATE Maryland	13b. COUNTY Charles	13c. CITY OR TOWN Hughesville										
14. FATHER'S NAME	FIRST Albert	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Jennie C. Proctor								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO. No 216-84-0348					17. INFORMANT Mrs. Mary Wood	ADDRESS 2520 Craine Hwy., Upper Marlboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						DUE TO, OR AS A CONSEQUENCE OF (b) _____  (c) _____						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <i>cardiovascular accident</i>												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/15 1980 to 8/16 1980, to 8/16 1980, that (I) (we) last saw the deceased alive on 8/16 1980 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Robert Harrison Proctor</i>	DEGREE					ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 8/16/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE 8/21/1980	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Calvary Cem.					23d. LOCATION CITY OR TOWN Upper Marlboro	COUNTY Md.	STATE F.C. Md.			
24. FUNERAL DIRECTOR NAME Martell Adams	ADDRESS Aquasco, Md.						25a. DATE REC'D. BY REGISTRAR AUG 19 1980	25b. REGISTRAR'S SIGNATURE <i>Lissey Melody</i>				

July 10, 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - FOR STATE REGISTRAR				8 0 2 0 8 0 5														
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR				
Sheridan				Eugene		Reaver	8 3 80							5:30 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male		White		Jan. 7, 1916			64				MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				MD.							
Maryland		U.S.A.					Carroll Co.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Taneytown		47 Frederick St.										Auto Mechanic		Automobile				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
13a. STATE Maryland	13b. COUNTY Carroll	13c. CITY OR TOWN Taneytown							47 Frederick St.									
14. FATHER'S NAME FIRST Irving				MIDDLE Grover	LAST Reaver	15. MOTHER'S MAIDEN NAME FIRST Ida				MIDDLE Grace	LAST Sprinkle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 216-05-0870				17. INFORMANT Mrs. Sheridan Reaver				ADDRESS 47 Frederick St. Taneytown, MD 21787						
18. CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Carcinoma of Prostate</i>																		
185- (c) <i></i>																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN	COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>February 19 12</u> , to <u>August 2 19 80</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>August 2 19 80</u> , and that in my <input checked="" type="checkbox"/> (law) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> <input type="checkbox"/> (did not) view the body after death.													22c. DATE SIGNED <i>8/5/80</i>					
22b. SIGNATURE <i>W. N. Iglesias</i>													DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wenifredo N. Iglesias, M.D.													22e. ADDRESS 49 Frederick Street Taneytown, Md. 21787					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Aug. 6, 1980			23c. NAME OF CEMETERY OR CREMATORIAL St. Josephs Cemetery				23d. LOCATION CITY OR TOWN Taneytown, Carroll, Maryland								
24. FUNERAL DIRECTOR NAME Skiles Funeral Home													25a. DATE REC'D. BY REGISTRAR 136 E. Baltimore St. Taneytown, MD 21787 AUG 8 1980					
													25b. REGISTRAR'S SIGNATURE <i>Henry Skiles</i>					



22



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, <sup>part 1</sup>  
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, <sup>part 2</sup>  
should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death  
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80	20806									
										REG. NO.		Estimated								
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR			
			RALPH			GEIMAN				Roop		August 8		1980	3A	M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
M			W			MONTH NOV DAY 27 YEAR 1900			79			MONTHS		DAYS		HOURS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND			USA						CARROLL											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
WESTMINSTER			940 RIDGE RD			DAIRYMAN			MILK											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
MARYLAND			CARROLL			WESTMINSTER						940 RIDGE RD.								
14. FATHER'S NAME			FIRST J O A L MIDDLE I LAST ROOP			15. MOTHER'S MAIDEN NAME			FIRST SALLY MIDDLE GEIMAN LAST											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			(IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO						214-36-9397			R. GARY ROOP			HYATTSVILLE, MD. 4003 UNDERWOOD ST								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>at</i> <i>Reposclerotic Cardiovascular Disease</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1970										
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first: (b) (c)																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Nov 16</i> , 19 <i>80</i> , to <i>Now</i> , 19 <i>80</i> , that (I) (we) last saw the deceased alive on <i>May 13</i> , 19 <i>80</i> , and that in (my) ( <input type="checkbox"/> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <input type="checkbox"/> ) (did) ( <input type="checkbox"/> ) view the body after death.																				
22b. SIGNATURE <i>J. H. Garicoffe MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/11/80</i>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. H. Garicoffe</i>			22e. ADDRESS <i>109 N Main Union Bridge MD</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>AUG 14-1980</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>PIPE CREEK</i>			23d. LOCATION CITY OR TOWN <i>NEW WINDSOR</i>			COUNTY		STATE <i>MD</i>						
24. FUNERAL DIRECTOR (NAME) <i>D. Hartzler New Windsor Md</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>AUG 14 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Patricia K. Hartzler</i>											

May 20

0801 a.m.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

MORE MARYLAND 21201 0 8 0 7

1. DECEASED-NAME (Type or print)		First <b>CARL</b>	Middle <b>(NMN)</b>	Lost <b>(HOHNER)</b>	20. DATE OF DEATH 08 Month 06 Day 80 Year <b>4:20 PM</b>	2b. HOUR	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>6-21-09</b>	6. AGE (In years lost birthday) <b>71</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Sykesville, Maryland</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield Hospital Ctr.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter (retired)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bldg.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Florida</b>		13b. COUNTY <b>Orlando</b>		13c. CITY OR TOWN <b>Orlando</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>650 N. Orange Ave.</b>	P.O. Box 3531
14. FATHER'S NAME First <b>William</b>		Middle <b>Palmer</b>	Lost	15. MOTHER'S MAIDEN NAME First Middle <b>Rose Lillian</b>		Lost <b>Davis</b>	Address
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-05-8539</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, pancreas</b> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 8</b> , 19 <b>80</b> , to <b>Aug. 6</b> , 19 <b>80</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Aug. 6</b> , 19 <b>80</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.							
22b. SIGNATURE <i>Lourdes Saradpon, M.D.</i>							
22c. DATE SIGNED <b>8-6-80</b>							
22d. PHYSICIAN'S NAME (Type) <b>Lourdes Saradpon, M.D.</b>		22e. ADDRESS <b>Springfield Hospital Center Sykesville, Maryland 21784</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-9-80</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Springfield Cemetery</b>	23d. LOCATION (City or Town) <b>Sykesville Carroll Md.</b>	(County)	(State)	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>		ADDRESS <b>Sykesville, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>Aug 19 1980</b>	25b. REGISTRAR'S SIGNATURE <i>Patricia Murphy</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL Cremation, or Removal.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

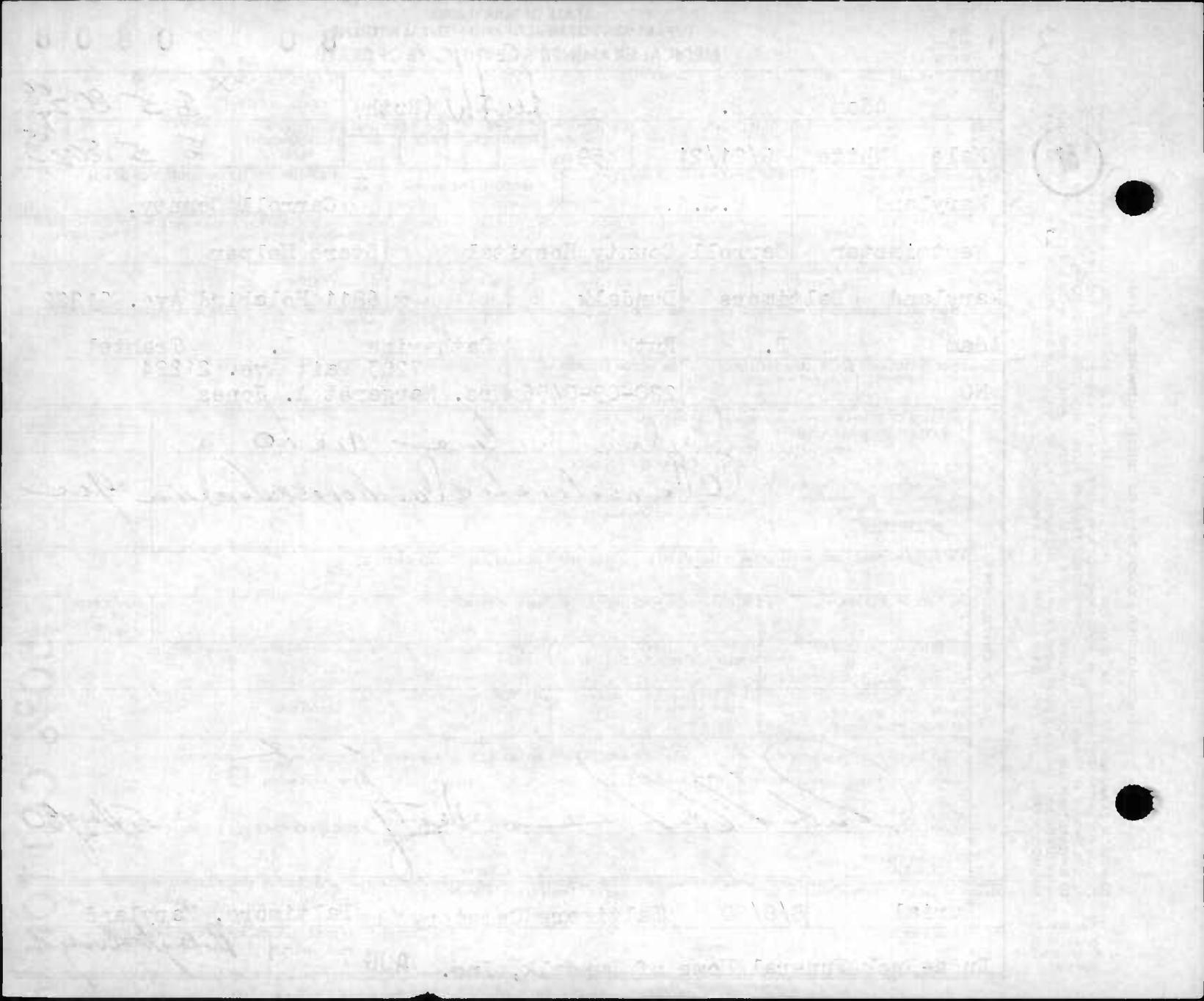
REG. NO.

8 0 2 0 8 0 8

I. DECEASED NAME (TYPE OR PRINT)			FIRST Adam	MIDDLE B.	LAST Ruth (Ruth)	2d. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 5 1980 2000 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6/21/21	6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <input checked="" type="checkbox"/> MONTH DAY YEAR 8 5 1980 2000 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Helper	
13a. STATE Maryland		13b. COUNTY Baltimore	13c. CITY OR TOWN Dundalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6811 Holabird Ave. 21222
14. FATHER'S NAME FIRST Adam		MIDDLE B.	LAST Ruth	15. MOTHER'S MAIDEN NAME FIRST Catherine		MIDDLE L. LAST Trantel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-09-0456		17. INFORMANT 7203 Fait Ave. 21224 Mrs. Margaret A. Jones		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Other arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held in Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>John C. Duda</i> TITLE & SPECIES M.D. Deputy MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/80	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN Baltimore, Maryland COUNTY STATE	
24. FUNERAL DIRECTOR NAME Duda-Ruck Funeral Home of Dundalk, Inc.		ADDRESS	25a. DATE REC'D. BY REGISTRAR AUG 7 1980		25b. REGISTRAR'S SIGNATURE <i>John C. Duda</i>	

BP  
DHMH - 17  
(VR A15 ME (5))  
15M7/77

4208



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8020809
1. DECEASED NAME (TYPE OR PRINT)			FIRST Neil	MIDDLE Elmer	LAST Sawyer	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH 8	DAY 13	YEAR 80	2b. HOUR M 11:25 A.M.
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 3, 1927</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52 yrs.</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH 8	DAY 14	YEAR 80	2d. HOUR A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Boston, Mass.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Hampstead</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shire House, North Carroll Shopping Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>	13b. COUNTY <b>Balto.</b>	13c. CITY OR TOWN <b>Owings Mills</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>121 Willow Bend Drive</b>					
14. FATHER'S NAME FIRST <b>Elmer</b>		MIDDLE 	LAST <b>Sawyer</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Shirley</b>		MIDDLE 	LAST <b>Myers</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>042-22-2363</b>		17. INFORMANT <b>Miss. Tracy J. Sawyer</b>		ADDRESS <b>Reisterstown, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Arteriosclerotic Cardiovascular Disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <i>4292</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		TITLE (SPECIFY) <b>Assistant M.D.</b>		MEDICAL EXAMINER		DATE SIGNED <b>8/15/80</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Virginia L. Dolan, M.D.</b>		ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Aug. 16, 80</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Westview Memorial</b>		23d. LOCATION CITY OR TOWN <b>Baltimore, Md.</b>				
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b>		24b. ADDRESS <b>Reisterstown, Md. 21136</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 18 1980</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2b is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 0 8 1 0			
										REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			7b. HOUR	
<b>LEONARD</b>			<b>George SCHUELER</b>			5 21 1904			NG 20 1980 0200				
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		White		5 21 1904			76						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore		U.S.A.					Carroll			MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Westminster		Carroll County General Hospital								Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Carroll		Westminster						753 Old New Windsor Pike			
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			ADDRESS			
William				Molly			216-03-1241			Westminster, Md. 21157			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for Part I and Part II) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No										HRS			
496-							HYPOTENESIS						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b)		DUE TO, OR AS A CONSEQUENCE OF			COPD			WEEKS			
{		{		DUE TO, OR AS A CONSEQUENCE OF			COPD			4 YRS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <i>COPD pneumonia</i>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)									
22a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT REST <input type="checkbox"/>		22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>819 80</i>		22c. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22d. I certify that (i) this hospital attended the deceased from now the deceased died on 19 80 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) we (do) not view the body after death.				19 80		to 19 80		19 80		that (i) we) lost			
22e. SIGNATURE <i>John P. Schueler MD</i>		22f. DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22g. DATE SIGNED <i>8/20/80</i>							
22h. PHYSICIAN'S NAME (TYPE OR PRINT)		22i. ADDRESS		22j. ADDRESS		22k. ADDRESS							
Burial		8/22/80		Glen Haven Memorial Park		Glen Burnie Arundel		Md.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR ADDRESS		25b. REGISTRAR'S SIGNATURE									
<i>John Fletcher</i>		Thomas D. Fletcher & Son F.H. 254 East Main St. West. Md.		AUG 25 1980		<i>John Fletcher</i>							

Monroe

berkman, father of Ernestine and Monroe, residence

old town and city, in the mountains, Monroe, Indiana

effort to control

to transfer to New Mexico

088 G SPWA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN  
retained by the hospital or attending physician

**FROM HOSPITAL TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. **FIG. 4**

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

8 0 2 0 8 1

REG. NO

1. DECEASED NAME (TYPE OR PRINT) <b>ALMA</b>			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
<b>Rosa SHRINER</b>						<b>9</b>	<b>30</b>	<b>80</b>	<b>11:50 AM</b>	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 9, 1890</b>				6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	IF UNDER 1 YEAR MONTHS <b>YRS</b>		IF UNDER 24 HRS HOURS <b>MIN</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b>					
10 CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>			
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Taneytown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>27 East Baltimore St.</b>				
14. FATHER'S NAME FIRST <b>Charles</b>	MIDDLE <b>E.H.</b>	LAST <b>Shriner</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Gertrude</b>			MIDDLE	LAST <b>Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. <b>220-44-3780</b>			17. INFORMANT <b>Mrs. Ray Warehime</b>			ADDRESS <b>2324 Feeser Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
<b>4140</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			<b>CARDIO-PULMONARY ARREST</b>							
DUE TO, OR AS A CONSEQUENCE OF (b)			<b>CONGESTIVE HEART FAILURE</b>							
DUE TO, OR AS A CONSEQUENCE OF (c)			<b>ASHD -</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>C-O-PD.</b>										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Malcolm J. Sevilla</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>SEP 4 1980</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Malcolm J. Sevilla</b>			22e. ADDRESS <b>419C Malcolm Dr. WESTMINSTER</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Sept. 2, 1980</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Carmel Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Littlestown, Adams Co., PA.</b>		23e. COUNTY <b>STATE</b>			
24 FUNERAL DIRECTOR NAME <b>Skiles Funeral Home</b>	136 E. Baltimore St. ADDRESS <b>Taneytown, MD 21787</b>	25a. DATE REGD. BY REGISTRY <b>SEP 4 1980</b>			25b. REC'D. BY REC'D. BY <b>Malcolm J. Sevilla</b>					

M

Box 4916

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE MARYLAND 21202

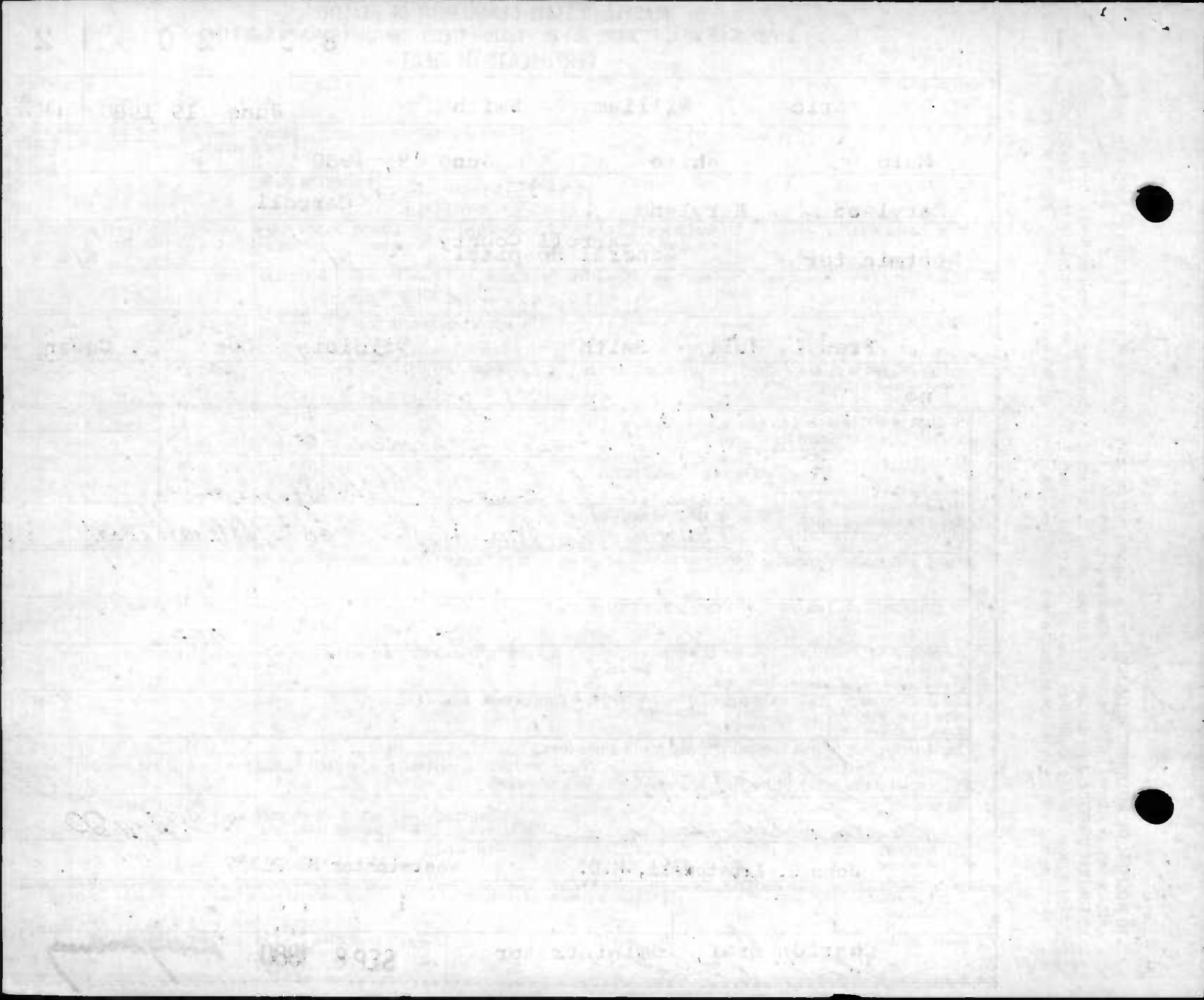
CERTIFICATE OF DEATH

80812

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First <b>Eric</b>	Middle <b>William</b>	Last <b>Smith</b>	20. DATE OF DEATH Month <b>June</b>	Day <b>19</b>	Year <b>1980</b>	2b. HOUR <b>5:10 AM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>June 19, 1980</b>				6. AGE (In years last birthday) YRS. <b>N/A</b>	IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS. HOURS <b>5</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH <b>Carroll</b>				Md.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll County General Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>N/A</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>					
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Manchester</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER <b>3262 N. Main St.</b>							
14. FATHER'S NAME First <b>Fred</b>	Middle <b>Julis</b>	Last <b>Smith</b>	15. MOTHER'S MAIDEN NAME First <b>Virginia</b>	Middle <b>Lee</b>	Last <b>Cowan</b>	Address					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>	16b. SOCIAL SECURITY NO.	17. INFORMANT								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Primary Atelectasis due to</i> <b>7566</b> DUE TO <input type="checkbox"/> AS A CONSEQUENCE OF <i>Chronic atelectasis due to absence of left diaphragm</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b) Chronic atelectasis due to absence of left diaphragm</b> DUE TO <input type="checkbox"/> AS A CONSEQUENCE OF <i>Abdominal viscera displaced to left hemithorax</i> <b>(c) Abdominal viscera displaced to left hemithorax</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John S. Ignatowski</i>		22c. DATE SIGNED <b>27 Aug 80</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>				
22d. PHYSICIAN'S NAME (Type) <b>John S. Ignatowski, M.D.</b>		22e. ADDRESS <b>Westminster MD 21157</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL <b>Charles Graf, Administrator</b>				23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR <b>Charles Graf, Administrator</b>	ADDRESS <b>Charles Graf, Administrator</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 8 1980</b>	25b. REGISTRAR'S SIGNATURE <i>John S. Ignatowski</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 0 8 1 3	
1 - FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
Evelyn		E	Evelyn	Smith	8 12 80						9 35 P.M.		
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		white		6 25 1905			75 YRS.						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			CARROLL			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY			MD.			
MANCHESTER		LONG VIEW NURSING HOME		HOUSEWIFE									
13a STATE Md.		13b COUNTY CARROLL		13c CITY OR TOWN Hampstead			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS RT. #1 Hampstead, Md.			
14 FATHER'S NAME FIRST Edward		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Effie						LAST Lippy			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 218-54-2714		17 INFORMANT Raymond Smith - Hampstead, Md.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 Mo. n.			
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (1a) <u>Cerebral Vascular Accident</u> 436- Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> 5 yrs. (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma Colon (post surgery)</u> <u>Arterosclerotic Disease</u>													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (if this hospital) attended the deceased from <u>6/3/80</u> , 19 <u>80</u> , to <u>8/12</u> , 19 <u>80</u> , that (we) last saw the deceased alive on <u>8/12</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) did/did not view the body after death.													
22b. SIGNATURE W.H. Ford MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/12/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. Ford MD		22e. ADDRESS 3223 Main St Manchester, Md 21162											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-15-80		23c. NAME OF CEMETERY OR CREMATORIAL Snyderburg Cemetery			23d. LOCATION CITY OR TOWN Hampstead			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		ADDRESS		25a. DATE REC'D. BY REGISTRAR AUG 20 1980			25b. REGISTRAR'S SIGNATURE Mary McCready						

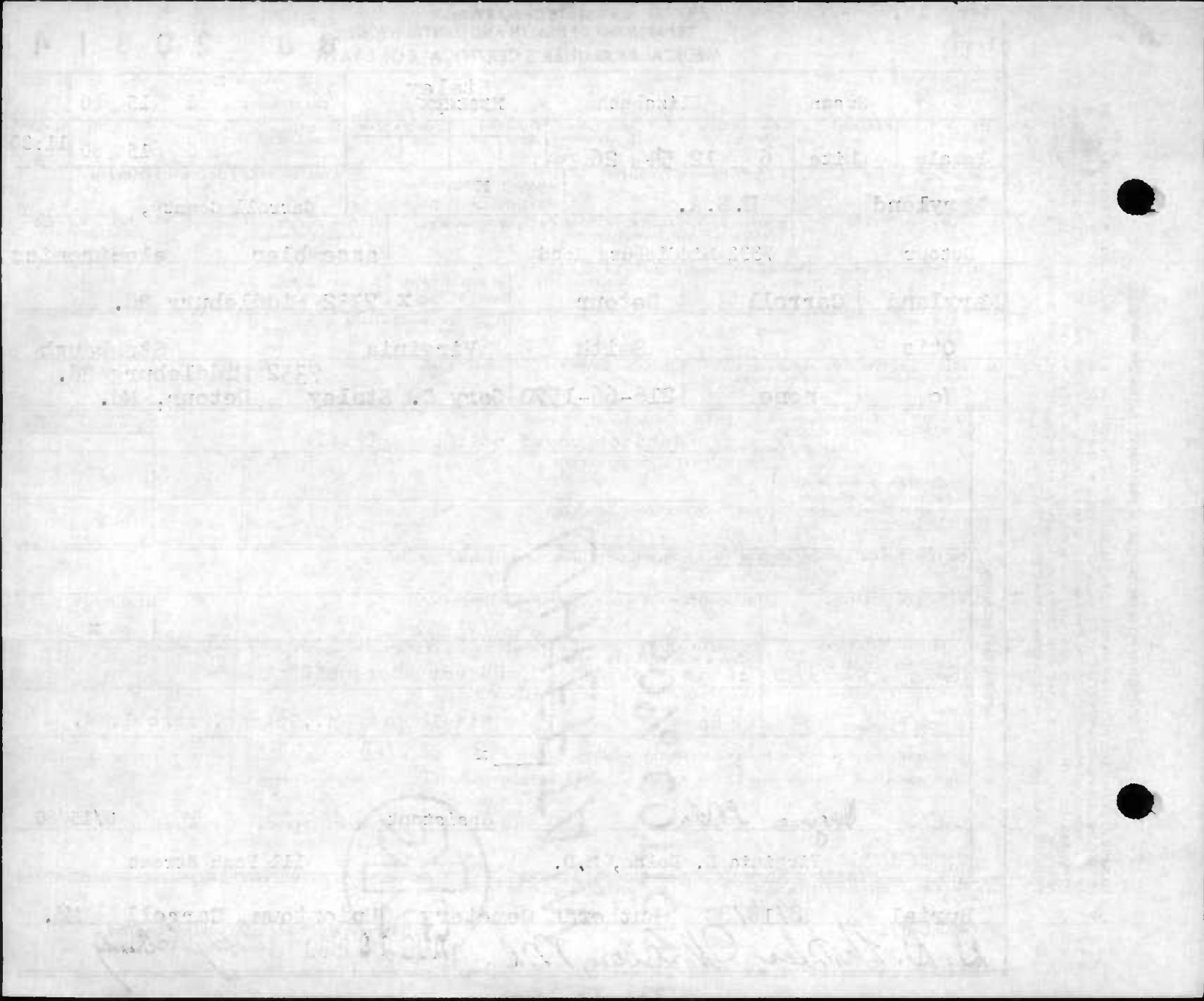
about south prairie grassland - 2000 ft.

Wet prairie - tall grasses - 2000 ft.

Wet prairie - stone - 2000 ft.

Items 18, 21b-22a G547 9/4/80 dad STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 8 0 2 0 8 1 4  
 REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Susan	MIDDLE Elizabeth	LAST Staley <i>Staleyy</i>	2a. DATE KNOWN OF DEATH ESTIMATED MATED	25 MONTH 8	DAY 15 <sub>19</sub> 80	YEAR M	2b. HOUR 11:30 A.M.	
3. SEX	4 RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH 8	DAY 15 <sub>19</sub> 80	YEAR A.M.	2d. HOUR 11:30 A.M.	
Female	White	6 12 54	26							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.			Carroll County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Detour		7332 Middleburg Road				Assembler		electronics		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Carroll		Detour	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7332 Middleburg Rd.			
14. FATHER'S NAME FIRST Otis		MIDDLE	LAST Smith	15. MOTHER'S MAIDEN NAME FIRST Virginia		MIDDLE	LAST Stambaugh			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. none		17. INFORMANT 7332 Middleburg Rd. Gary C. Staley Detour, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9552 IMMEDIATE CAUSE (a) Gubshot wound of chest (rifle) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7:45 AM 8/15/80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) subject shot self		21f. LOCATION STREET 7332 Middleburg Rd., Detour, Carroll, Md.		CITY OR TOWN COUNTY STATE		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Virginia L. Dolan</i>		EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED 8/15/80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/18/80		23c. NAME OF CEMETERY OR CREMATORIUM Lutheran Cemetery		23d. LOCATION CITY OR TOWN Uniontown		COUNTY Carroll		
24. FUNERAL DIRECTOR NAME <i>D. N. Shatzler</i>		ADDRESS Worrellboro, Md.		25. DATE REC'D. BY REGISTRAR AUG 20 1980		25. REGISTRAR'S SIGNATURE <i>Larry McCreary</i>				
BP		DHMH - 17 (VR A15 ME (5)) 15M7/77								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 0 8 1 5			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Frederick A. Sweitzer						8 13 80			0159 M				
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male		White		March 5, 1910			70 YRS.						
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Md.		U.S.A.					Carroll						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Westminster		Carroll Co. Hospital								Sheet Metal Worker D.C.A.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Md.		Howard		Sykesville						1400 Rt. 97			
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME						
Jeremiah				Sweitzer			Martha			Friend			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))			ADDRESS			
No		214071406					CRIMINAL ARREST			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR			
4140		DUE TO, OR AS A CONSEQUENCE OF (b) ATHERO SCLEROTIC CORONARY DISEASE									YEARS		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASPIRATION													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1966 to 8/13 1980, that (I) (we) last saw the deceased alive on 8/17 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/13/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Vincent J. Fioccio Jr. MD		Westminster, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Cemetery			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE		
Burial		8-15-80		Crestview Cemetery			Towson		Baltimore		Md.		
24. FUNERAL DIRECTOR NAME		ADDRESS			25. DATE RECEIVED BY FUNERAL DIRECTOR			25b. REGISTRATION SIGNATURE					
Harry W. Haight		Sylvanville, Md.			AUG 18 1980								

1805 18

089 1805

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

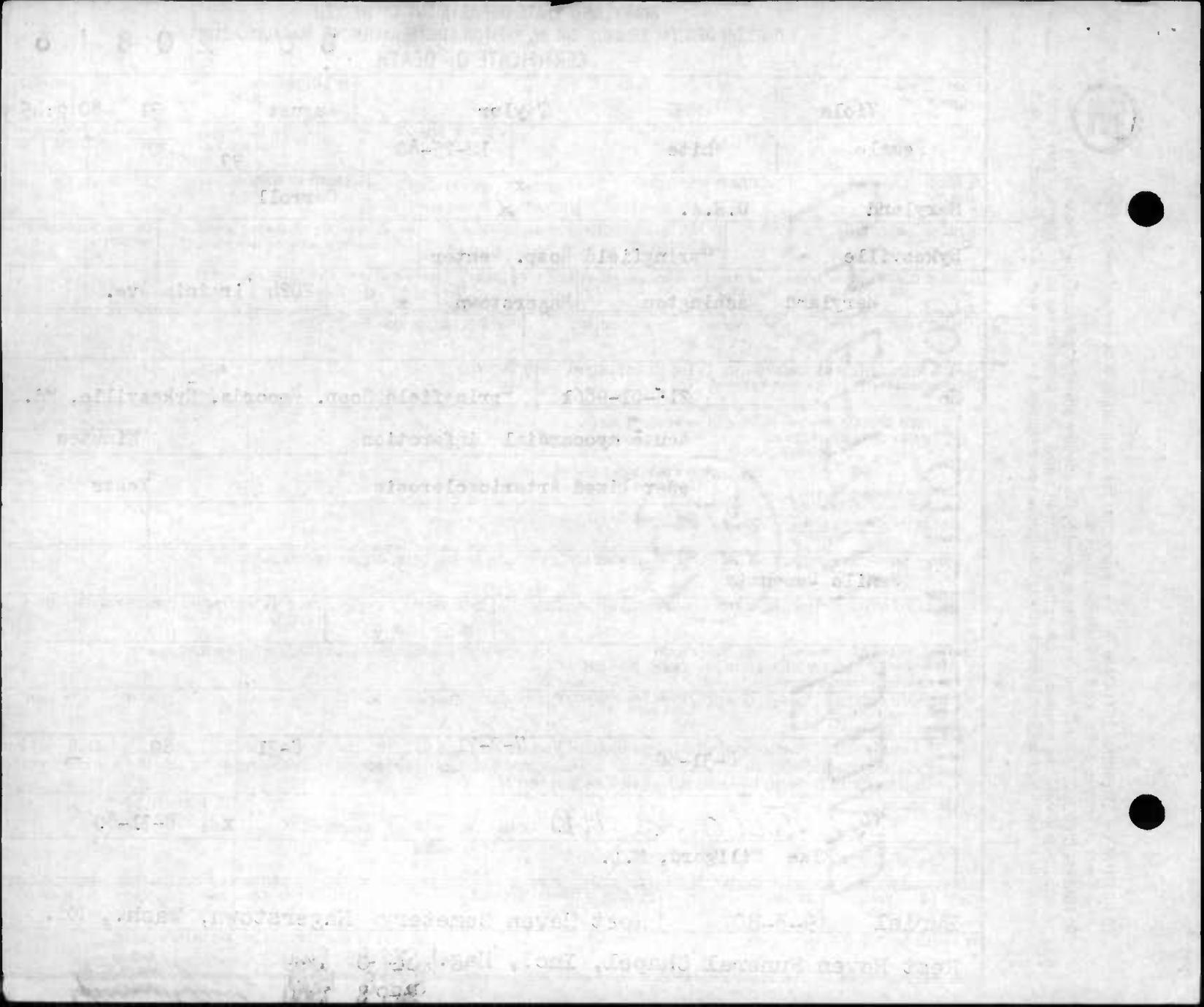
CERTIFICATE OF DEATH

20816

1. DECEASED NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR	
				Viola	NMN	Taylor	August		31	80	2:45 PM	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White	18 12-25-80			99 YRS.			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		NEVER MARRIED	<input type="checkbox"/>	9. COUNTY OF DEATH			
Maryland		U.S.A.			WIDOWED		DIVORCED	<input checked="" type="checkbox"/>	Carroll			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield Hosp. Center									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2024 Virginia Ave.				
14. FATHER'S NAME				First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No				215-01-9861			Springfield Hosp. Records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction Minutes												
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Generalized Arteriosclerosis Years												
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Senile Dementia												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS DE CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 7-2-71, 19, to 8-31, 1980, that (I) (we) lost saw the deceased alive on 8-31-80 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Else Millgard MD</i>		22c. DEGREE ATTENDING PHYS.		MED. DIRECTOR		STAFF PHYS.		22c. DATE SIGNED 8-31-80				
22d. PHYSICIAN'S NAME (Type)		Else Millgard, M.D.		22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 9-3-80		23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		23d. LOCATION (City or Town) Hagerstown, Wash., Md.		(County)		(State)		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR J.W. 8 1980		25b. REGISTRAR'S SIGNATURE <i>SEP 8 1980</i>						

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8020817							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR							
Elizabeth Mary			Triff Tripp			84 803			M			10:00 AM							
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE IN YEARS LAST BIRTHDAY	7. IF UNDER 1YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	9c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR							
Female	White	10 11 01	78 yrs.			84 804			A			10:00 AM							
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		9. DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH										
Washington, D.C.		U.S.A.							Carroll										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12. USUAL OCCUPATION (TYPE OF WORK FOR PRACTICING LIFE)			13. KIND OF BUSINESS OR INDUSTRY											
New Windsor		404 High St.			Owner			operator											
14. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS									
Maryland		Carroll		New Windsor		YES <input checked="" type="checkbox"/>		404 High St.		404 High St.									
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
Ernest H. Rhodes		Catherine		Roache															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No none		579-42-6191		Elizabeth M. Tripp		New Windsor, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for item 18a, (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4292 <i>Hemorrhagic Cardiosacular Disease</i>																			
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last } (b) } DUE TO, OR AS A CONSEQUENCE OF } (c) } DUE TO, OR AS A CONSEQUENCE OF }																			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?													
						YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that I took charge of the remains described above. Held in Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED		8/4/80					
ACTUAL SIGNATURE <i>Richard A. Jones</i>												TITLE (SPECIFY) M.D.		MEDICAL EXAMINER			Carroll County General Hosp.		
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones												ADDRESS		Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/17/80			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Washington, D.C.			COUNTY		STATE					
24. FUNERAL DIRECTOR NAME <i>D. D. Hartzer</i>			ADDRESS New Windsor, Md.			25e. DATE REC'D. BY REGISTRAR AUG 6 1980			25f. REGISTRAR'S SIGNATURE <i>Eugene Kennedy</i>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign the certificate and return it to the funeral director on page 3.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, it should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 0 8 1 8				
1 - FOR REGISTRAR											REG. NO.					
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Viva			V.		Trump	8 3 80			8	3	80	5 A.M.				
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>10 27 1899</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ma.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b>			MD.				
10. CITY OR TOWN OF DEATH <b>Manchester</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Longview NSG Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Ma.</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>Manchester</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>North Main Street</b>				
14. FATHER'S NAME FIRST <b>Theodore</b>			MIDDLE <b>Fredrick</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Amelia</b>			16. ADDRESS <b>Towson, Md. 21204</b>				LAST <b>Hekkenkoren</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>219-14-12840</b>			17. INFORMANT <b>Cheystelle Bond (daughter)</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>C.V. Accident</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>March, 1981</b>			
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b) <b>As Sclerotic C.V. Disease</b>			(c) <b>Urinary Tract Infection</b>							years. <b>3 mo.</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-3 1980</b> , to <b>8-3 1980</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>8-3 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We did) (did not) view the body after death.																
22b. SIGNATURE <b>M.C. Porterfield M.D.</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8-3-80</b>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M.C. PORTERFIELD</b>			22e. ADDRESS <b>HAMPSTEAD, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-6-80</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Immanuel Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Manchester</b>			COUNTY <b>Carroll</b>		STATE <b>Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Hampstead, Md.</b>			ADDRESS <b>21074</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 13 1980</b>			25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or pending any event, within 72 hours after death.

1. DECEASED NAME (Type or print)				First	Middle	Lost	2d. DATE OF DEATH	2b. HOUR
				Katie	Dell	Underwood	8 8 80	8 P.M.
3. SEX		4. RACE			5. DATE OF BIRTH		6. AGE (In years last birthday)	2b. HOUR
Female		Negro			12-15-12		67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?			B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
N.C.		USA					Carroll County	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville, Md.		Springfield Hospital Center						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER		
MD		Baltimore			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	2637 Loyola Southway		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		Middle	Lost
		Willie	Fowler		Creasanna		Culbreth	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
No		N/A			Nannie P. Fowler		924 N. Payson St.	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>Aspiration pneumonia</b> <b>IMMEDIATE CAUSE (a)</b> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>ASCVD</b> <b>(b)</b> DUE TO, OR AS A CONSEQUENCE OF <b>lost.</b> <b>(c)</b> <b>years</b>								
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)</b> <b>Psychosis with metabolic or nutritional disorder/. Diabetes mellitus</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>October 31, 1969</u> , to <u>Aug. 8, 1980</u> , that (I) (we) last saw the deceased alive on <u>August 8, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Elise J. Robinson, M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> DATE SIGNED <u>8/8/80</u>								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			Sykesville, Springfield Hospital Center Md. 21784			
Elise J. Robinson, M.D.								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City or Town)	(County)	(State)
Burial		8/16/80		Hillcrest Cemetery		Sampson	Co.	N.C.
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REC'D REG. SIGNATURE	
Wm. C. March F/H		1101 E. North Ave.					AUG 12 1980	

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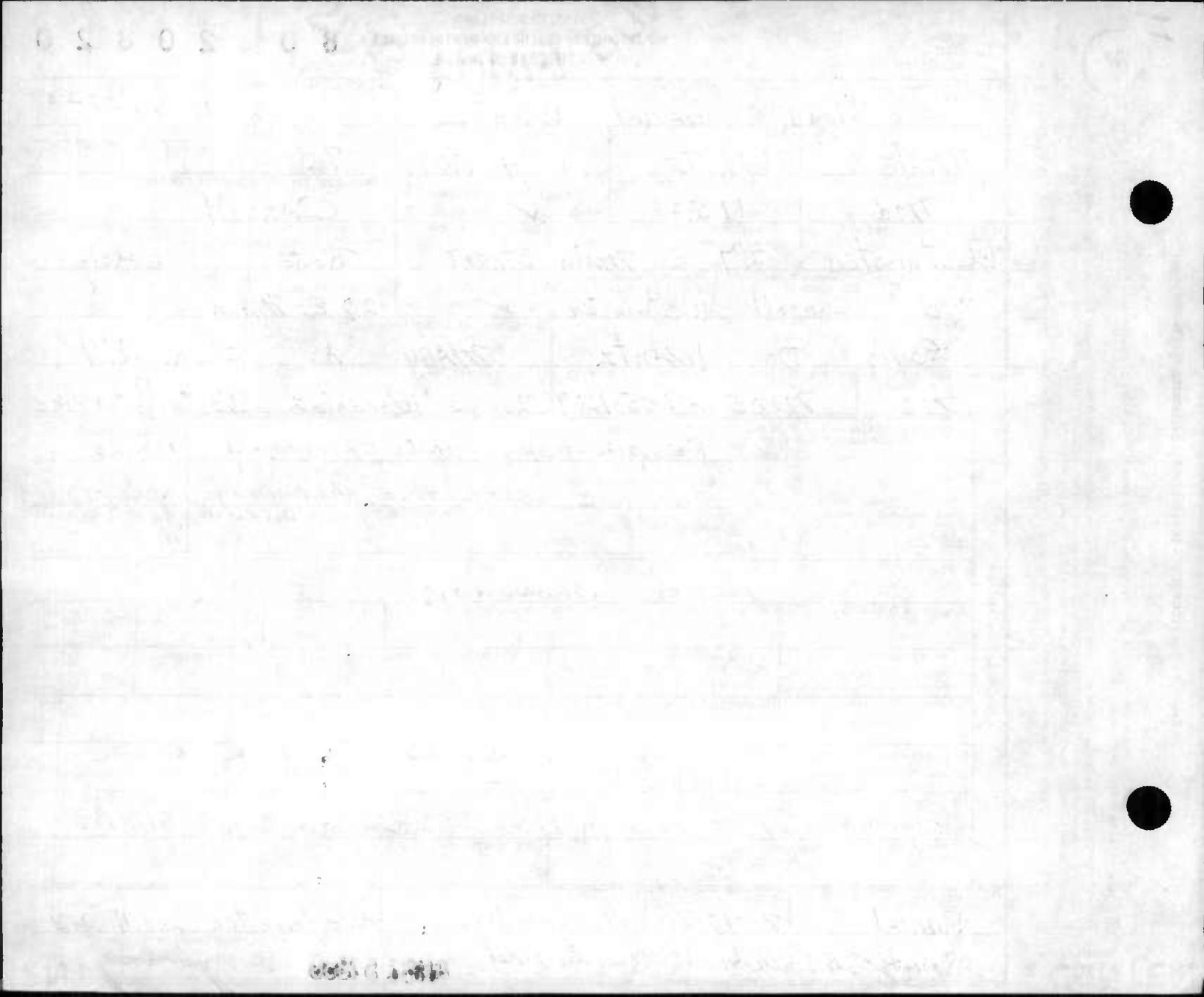
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020820				
										REG. NO.				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR		2b HOUR			
			<i>Lloyd Daniel Wantz</i>						8 11 80		0523			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
<i>Male</i>		<i>White</i>		1 4 1907			73 YRS							
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 B BALTIMORE CITY OR COUNTY OF DEATH			MD.				
<i>Md.</i>		<i>USA</i>					<i>Carroll</i>							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
<i>Westminster</i>		<i>27 E. Main Street</i>			<i>Route</i>			<i>Bakely</i>						
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS					
<i>Md.</i>		<i>Carroll</i>		<i>Westminster</i>		YES <input type="checkbox"/>			<i>27 E. Main</i>					
14 FATHER'S NAME		FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO.			17 INFORMANT	
<i>Louis</i>		<i>D. Wantz</i>		<i>MARY A. Sookingbill</i>			<i>770 70ME</i>			<i>213-05-1209</i>			<i>Bonnie Warehime Westminster, Md</i>	
18 CAUSE OF DEATH (Enter only one cause per line for 1(a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>496-</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS				
(b) <i>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</i>										<i>YEARS</i>				
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a MEDICAL CERTIFICATION			19b DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE								
22a I certify that (I) (this hospital) attended the deceased from <i>8/10 1980</i> to <i>8/10 1980</i> , that (I) (we) lost the deceased alive on <i>8/10 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <i>8/10/80</i>				
22b SIGNATURE <i>Vance J. Jones Jr. MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIES)			23b. DATE <i>8-13-80</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Meadow Branch</i>			23d. LOCATION CITY OR TOWN <i>Westminster Carroll Md</i>			COUNTY STATE		
24 FUNERAL DIRECTOR <i>Robert Kyle Brith Jr. Westminster, Md.</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>Aug 15 1980</i>			25b. REGISTRAR'S SIGNATURE <i>Robert Kyle Brith Jr. Westminster, Md.</i>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 0 2 0 8 2 1							
1- STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				FIRST John				MIDDLE Herbert		LAST White		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 2 19 80		2b. HOUR M			
3 SEX male	4 RACE white	5. DATE OF BIRTH MONTH 3 DAY 17 YEAR 40			6 AGE (IN YEARS LAST BIRTHDAY) 40 YRS.			IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN		2c. DATE PRONOUNCED DEAD 8 6 19 80		2d. HOUR 1:10 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Liberty Reservoir						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer						12b. KIND OF BUSINESS OR INDUSTRY Upholstery					
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Berrymans Lane											
14. FATHER'S NAME FIRST Karl		MIDDLE W.		LAST White		15. MOTHER'S MAIDEN NAME FIRST Doris						MIDDLE M.		LAST Campbell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-30-1600		17. INFORMANT						ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Drowning												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
984- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF							
(b)												DUE TO, OR AS A CONSEQUENCE OF							
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY P.M. 8 2 19 80				est.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found in reservoir							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) found				21f. LOCATION STREET				CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>																			
ACTUAL SIGNATURE <i>Hormez R. Guard</i>		TITLE (SPECIFY) Assistant		M.D.		MEDICAL EXAMINER		DATE SIGNED 8/7/80											
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Baltimore, MD 21201																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 8/18/80		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		COUNTY		STATE							
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR AUG 20 1980						25b. REGISTRAR'S SIGNATURE <i>Patsy McCreedy</i>									
BP		DHMH - 17 (VR A15 ME (5)) 15M7/77																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8020822			
1 - STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Marvin L. Wilson							Aug 3, 1980			000 AM			
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
Male		White		MONTH 3 DAY 2 YEAR 1900			80 YRS			IF UNDER 24 HRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland		USA					Carroll Co.						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County Gen'l Hospital							Farmer				
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Manchester			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS S. Main Street			
14. FATHER'S NAME Andrew		FIRST	MIDDLE	LAST Wilson			15. MOTHER'S MAIDEN NAME Alta			MIDDLE	LAST Bailey		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. no		16c. SOCIAL SECURITY NO. 220-30-6069			17. INFORMANT Mrs. Florence Bankert, Westminster, Md.			ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i>  4295 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Cardiac arrest</i>  (c) <i></i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 3, 1980</i> , to <i>Aug 3, 1980</i> , that (I) (we) last saw the deceased alive on <i>Aug 3, 1980</i> . And that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												22c. DATE SIGNED 8/3/80	
22b. SIGNATURE <i>John S. Harshey, MD</i>		22d. DEGREE <i></i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOHN S. HARSHEY, MD</i>		22f. ADDRESS <i>8 Andrew St. Westminster, Md. 21157</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-5-80		23c. NAME OF CEMETERY OR CREMATORIAL St. David's (Shermans)			23d. LOCATION CITY OR TOWN W. Manheim Twpsh		COUNTY York	STATE Pa.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		25a. DATE REC'D. BY REGISTRAR AUG 13 1980			25b. DATE REC'D. BY CLERK <i></i>								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8020823						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR						
			ROBERT A.			WILSON			8-30-80			1852 M						
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN						
M		W		25 11 - 08 - 1900			54 yrs											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Maryland		USA					CARROLL Co.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Westminster		Carroll County Gen'l Hospital			Tow Lift			B & D										
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4120 Upper Beckleysville Road								
14. FATHER'S NAME FIRST James		MIDDLE		LAST Wilson			15. MOTHER'S MAIDEN NAME FIRST Edna			MIDDLE		LAST Bell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Mrs. Margaret A. Wilson, Hampstead, Md.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 99 minutes								
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Cardiac Arrest																
410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction									10 hours							
		DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Diabetes Mellitus.																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8-30-1980, to 8-30-1980, that (I) (we) last saw the deceased alive on 8-30-1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Chitrachedu Naganna		DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/30/80										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 174 E Main St. Westminster MD 21157																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-80		23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove Cemetery			23d. LOCATION CITY OR TOWN Parkton			COUNTY Balto		STATE Md.						
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		ADDRESS 25. DEPT. REC'D. BY 1000			25. DEPT. REC'D. BY 1000			25. DEPT. REC'D. BY 1000										

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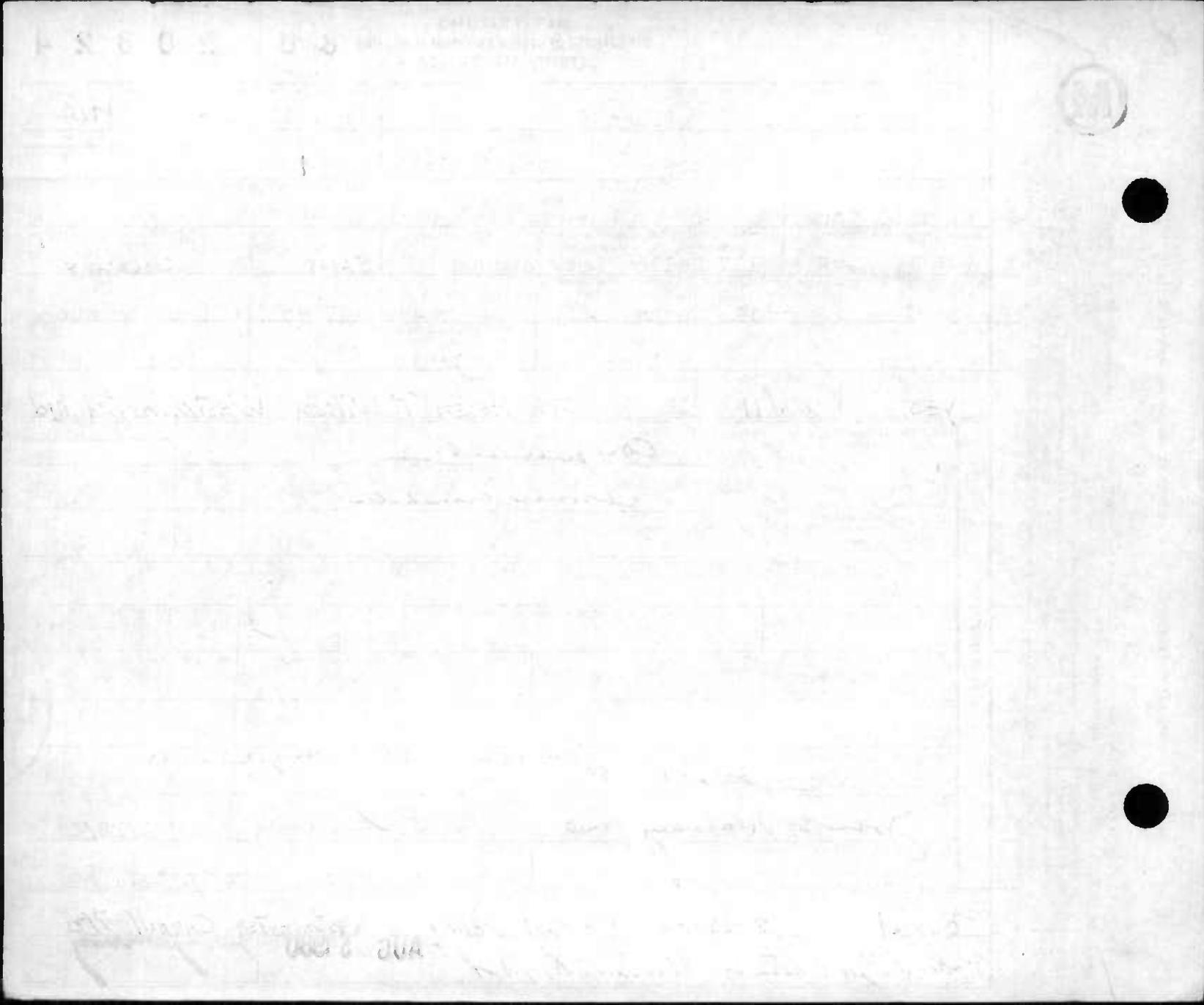
10000 10000 10000 10000 10000 10000 10000 10000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

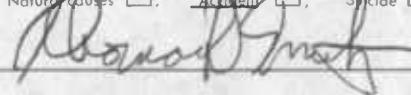
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	8 0 2 0 8 2 4						
1. FOR - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR					
Robert E. Wilson									Aug. 17, 1980			7:15A M					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll		
Male		White		Jan 16 1919			6 0 YRS			Carroll County USA		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Baltimore City or County of Death Carroll		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		137 Hollow Rock Avenue										SALES		COOKWARE			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		13f. ADDRESS					
Maryland		Carroll		Westminster			14. FATHER'S NAME FIRST MIDDLE LAST			Olivia		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Harry		Wilson					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		16c. INFORMANT			16d. ADDRESS		
YES		WWII					220-16-0377			HELEN P. Wilson		Westminster, Md			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																	
4919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)														Cor pulmonale			
DUE TO, OR AS A CONSEQUENCE OF chronic bronchitis (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from June 20, 1980, to Aug 17, 1980, that (I) (we) last saw the deceased alive on July 29, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE John S. Harshey, M.D.														22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Harshey, M.D.														22e. DATE SIGNED 8/18/80			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. REC'D. BY CLERK, STAR 215 REC'D. BY CLERK, STAR 215 REC'D. BY CLERK, STAR 215							
Burial		8-20-80		PLEASANT VALLEY			WESTMINSTER Carroll 711			CARROLL 711							
24. FUNERAL DIRECTOR Robert E. Pitts Jr. Westminster, Md.		ADDRESS		25. REC'D. BY CLERK, STAR 215 REC'D. BY CLERK, STAR 215 REC'D. BY CLERK, STAR 215													



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8020825			
1- FOR STATE REGISTRAR															
1. DECEASED NAME (TYPE OR PRINT)		William Eline		LAST Wisner		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH DAY YEAR		2b. HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
Male		White		4 29 1908		72 yrs.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		* NEVER MARRIED DIVORCED		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR					
Maryland		USA						8 22 19 80		24 HOUR 2:17P M					
9. BALTIMORE CITY OR COUNTY OF DEATH		Carroll County MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			
Finksburg		Rt. 140 1 mile w. of KeysMill Rd.										12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4704 Dave Rill Road							
14. FATHER'S NAME FIRST Eli		MIDDLE		LAST Wisner		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE		LAST Baublitz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-16-1039		17. INFORMANT Mrs. M. Ray Wisner. Hampstead, Md.		ADDRESS									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Traumatic injuries DUE TO, OR AS A CONSEQUENCE OF  8159 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR XX. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		Rt. 140 1 mile w. of KeysMill Rd. Carroll, Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE 												TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.										ADDRESS 111 Penn St. Balto., MD.			
23a. BURIAL, CREMATION, REMOVAL SPECIES		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE					
Burial		8-26-80		Hampstead Cemetery		Hampstead		Carroll		Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS Eline Funeral Home, Hampstead, Md. 21074										25a. DATE REC'D. BY REGISTRAR AUG 26 1980		25b. REGISTRAR'S SIGNATURE 	

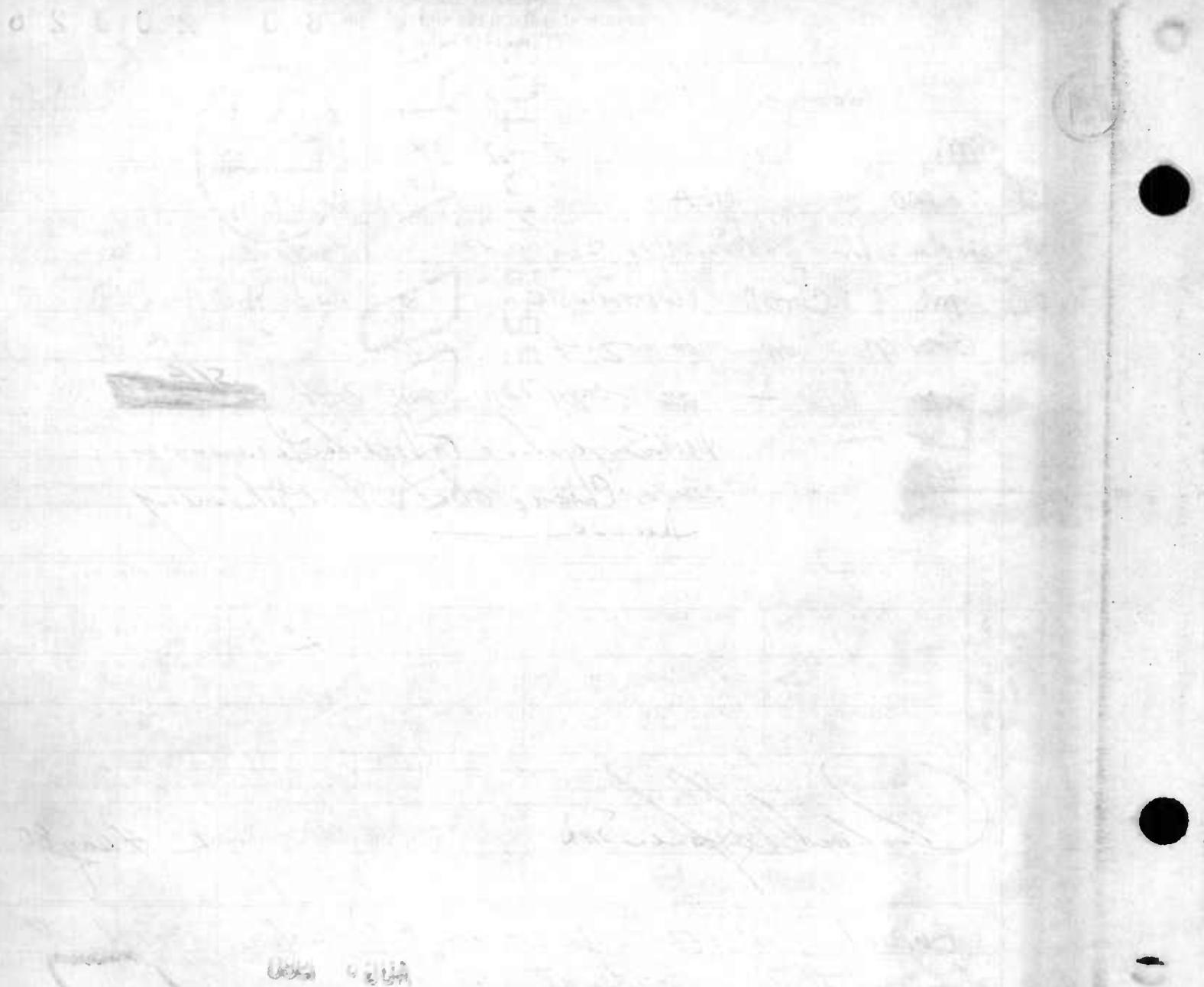
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 0 8 2 6			
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR	
<i>George A.</i>						<i>Zepf</i>	<i>8/2/80</i>							<i>1140 AM</i>	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS		
<i>m</i>		<i>W</i>		MONTH	DAY	YEAR	<i>5 2 08</i>				MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				10. CITY OR TOWN OF DEATH				
<i>MD.</i>		<i>USA</i>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Carroll</i>				<i>Westminster</i>				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				13a. STATE					
<i>Carroll Co. Gen Hosp</i>		<i>Mechanic</i>				<i>Plant</i>				<i>MD.</i>					
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS							
<i>Carroll</i>		<i>Westminster</i>		<i>No</i>				<i>3231 Nicholson Rd</i>							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME				FIRST	MIDDLE	LAST				
<i>George</i>			<i>Washington</i>	<i>Zepf</i>	<i>Laural</i>						<i>Bish</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS							
<i>No</i>		<i>— 916-05-1401</i>		<i>Catherine Zepf.</i>				<i>St. A [REDACTED] Westminster</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<i>496 - Hematopoietic Orthosthenia</i>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) { DUE TO OR AS A CONSEQUENCE OF <i>Syndrome Chronic obstructive pulmonary</i> (b) DUE TO OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (the hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We and) (did not) expect the body after death.												22c. DATE SIGNED <i>4 Aug 80</i>			
22b. SIGNATURE <i>Donald J. Zepf, MD</i>		22c. DEGREE <i>MD</i>				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIANS					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL SPECIAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS				23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. BURIAL, CREMATION, REMOVAL SPECIAL			
<i>Burial</i>		<i>8/4/80</i>		<i>Deer Park</i>				<i>Smallwood</i>		<i>Carroll</i>		<i>Smallwood</i>			
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE									
<i>A. G. Little Jr.</i>		<i>Aug 5 1980</i>				<i>[Signature]</i>									



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